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ARMA CARE CENTER LLC	605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712

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F 000	INITIAL COMMENTS The following citations represent the findings of a health facility re-survey. An electronic revision was emailed to the facility on 5/4/12.	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on record review and interview of personal funds, the facility failed to return, within 30 days, the deceased resident's remaining personal funds. This deficient practice affected 1 of 1 (non-sampled) residents reviewed. Findings included: - On 5/1/12 at 1:30 PM, interview and electronic record review of the resident's funds, with administrative staff E, reported the facility continued to hold $8.05 for a non-sampled resident, who expired on 12/31/12. Administrative staff E reported, on 5/1/12 at 1:30 PM, indicated the facility held the monies in the expectation of additional funeral expenses, for the resident.	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160	Continued From page 1 The facility failed to return deceased resident's funds within 30 days of death, as required.	F 160		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents with 3 selected for sample review of personal property. Based on observation, record review, and interview, the facility failed to promptly resolve reports of missing property for 1 (#9) of 3 resident's reviewed, for personal property. Findings included: - The facility admitted resident #9 on 12/3/01. The resident's quarterly 2/20/12 MDS (minimum data set), identified a BIMS (brief interview for mental status) score of 15, indicating cognition intact, and identified the resident independent with adl's (activities of daily living). Review of the 4/11/12, resident council minutes, reflected the resident reported during the meeting, a pair of pink sweat pants, missing. On 4/25/2012 at 10:09 AM the resident explained a missing pair of pink pants and the resident did report the missing clothing to staff members, who stated they would be looking for them.	F 166		

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F 166	Continued From page 2 On 4/30/12 at 10:55 AM, interview with direct care staff P, reported the staff are instructed to notify the charge nurse when a resident states an item is missing. The staff reported a lack of knowledge of any missing property for this resident. Interview with direct care staff, S, reported on 4/30/12 at 4:15 PM, when notified of a missing item by the residents, then a note is left for the housekeeping and laundry staff, related to the item. On 5/1/12 at 10:30 AM, administrative staff A and administrative nursing staff B, reported awareness of the residents missing clothing. Staff B stated, "We often find [this resident's] clothing in another residents closet." Administrative nursing staff B further stated, this occurred due to a very similar last name. When inquired if the staff had checked the other resident's closet, staff B, responded, "Not yet." Activity/Social Service staff D, on 5/1/12 at 2:45 PM, reported an awareness of the resident's missing pants for, "A few weeks," and the facility planned to replace the missing pants, as staff failed to locate the resident's missing property. Staff D failed to identify a time frame for replacing unfound, lost, items for the residents reporting them. The facility policy for Lost and Found, dated 4/08, included: "...8. Reports of misappropriation or mistreatment of resident property are immediately investigated."	F 166		

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F 166	Continued From page 3 The facility failed to investigate and respond to the residents report of the missing pants, for at least 20 days.	F 166		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services on 2 of 2 resident hallways, including, the west hallway 3 in resident rooms, nurses desk and central bath. The east hallway 3 in resident's rooms, the central bath, the smoke room, and the physical therapy room for the residents of the facility. Findings include; - On 5/1/12 at 10:30 A. M., during environmental tour of the facility, the following resident areas reviewed in need of housekeeping and maintenance services as follows: The west hallway; 1.) The nurses desk: laminate covering lacked several areas leaving only unpainted wood. The cork along the nurses desk missing approximately a 5 inch piece. Scurf marks noted along the bottom of the nurses desk on the outside	F 253		

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F 253	Continued From page 4 2.). One resident bathroom contained a yellow orange discoloration around the base of ther toilet, with a large "puddle" of wetness noted. 3.) One resident room contained carpet with several large stains noted approximately 1 foot in diameter. 4.) One resident room contained a marred wall with 6 area's of missing paint at the door,1 inch by 1 inch each. The linoleum in the bathroom held a large gray discoloration area around the toilet base. The wall above and behind the night stand, contained a marred area 6 inch by 2 foot. 5.) The living area beside the west hall nurses desk, noted a large piece of raw wood, approximately 3 feet by 3 feet, attached to the ceiling. 6.) The resident's whirlpool bathroom, held a 5 foot in length by 1 foot in width, area missing the paint; on the wall between the whirlpool and window, approximately 2-3 feet from the floor, a 1 foot by 1 foot piece of sheet rock cut out, and missing 6 screws. The linoleum in the room held a gray discoloration noted in front of the shower. 7.) The carpeting throughout the west hallway contained various sized stains. On 5/1/12 at 10:30 A. M., maintenance personal H, reported, " I just covered the hole up in the ceiling yesterday evening when the wood arrived. The cut out sheetrock was probably from an access panel they forgot to put the trim on."	F 253		

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F 253	Continued From page 5 The east hallway; 1.) One resident room, furnishings contained a layer of dust, including the window sill, lamp, television and digital video disk player along with the pictures on the wall. 2.) One resident room's window ledge, zone air/heat unit held a layer of dust and a type of granules on them. 3.) One resident shower room on the east hall, contained numerous gray discoloration area's to the linoleum, and the tan tile in the showers discolored to brown. The laminate on the counter top of the sink discolored with a white/gray color. 4.) The carpeting through the east hallway contained various sized stains. 5.) The smoke room held, 3 large water stains on the ceiling, approximately 1 foot in diameter, with the plaster cracking. The entire floor in the room held dark brown discoloration around the edges of the floor where it meets the wall, approximately 1/2 inch. 6.) The therapy room floor held dirt, dark gray in color, with the ability to note where the desk chair moved on the floor. The refrigerator in the room contained numerous areas of dried substance, and the refrigerator dirty. The freezer contained a dried pink substance noted on the floor of the freezer. The stove contained "crumbs" on the	F 253		

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F 253	Continued From page 6 top. The microwave on the counter, a yellow substance noted underneath it and the inside with dried food areas. The microwave also lacked the glass "plate" which sits in it, only the carousel is in it. On 5/1/12 at 10:30 A. M., consultant staff L, reported, " I don't know who is to clean the room. The food is the staffs, they bring it here because it is closer. I sweep the floor." On 5/1/12 at 10:30 A. M., housekeeping staff I, reported, " Housekeeping is to clean this room." The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for the resident areas.	F 253		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 32 residents with 14 residents selected for sample review. Based on observation, interview, and record review, the facility failed to develop an individualized comprehensive plan of care for 6 of the 14 residents reviewed. This included residents: #5 for bruising, #43 for pain interventions, #49 for appropriate pressure relieving devices, #4 for activities, #34 for behaviors, bruising and an individualized bladder program, and #37 for lack of care planning for hospice services.

Findings included:

- The facility admitted resident #5 on 1/9/07, with diagnosis including: multiple sclerosis, depressive disorder, anxiety disorder, vitamin deficiency, muscle spasm, osteoporosis, pain, stomach function disorder, and eye disorder.

A quarterly, 1/30/12, MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) of 13, indicating cognitively intact, transferred with limited assistance of 1 staff, and lacked identification of any skin issues.

Review of "The Weekly Skin Assessment Record," dated 4/2012, identified the following:
4/3/12, No new issues to skin noted.
4/10/12, Bruise to right breast, states during

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self-transfer, no other issues to skin at this time.
4/17/12, Healing bruise to right breast, no other issues noted to skin.
4/24/12, No new issues to skin noted.

The resident's care plan, dated 5/11/11, identified the resident received prednisone daily, used a wheel chair independently for mobility, directed staff to monitor the resident for coordination and weakness, related to MS (multiple sclerosis), a history of falls, and self transferring. However, the care plan lacked any instructions to the staff to prevent further skin bruising for the resident.

Observation on 4/26/2012 at 9:31 AM, identified multiple, various sized bruised areas to the resident's bilateral arms, and abrasions to the resident's knees. At that time, the resident stated, "I run into things all the time."

Interview on 4/30/12 at 10:47 AM, with direct care staff P, reported the resident usually independent with ADL's (activities of daily living). Inquiry on the staff's knowledge of procedure for reporting injuries to resident's identified the staff are trained to, "Note on the shower sheets all new bruising and tell the charge nurse daily when see a new area. Or, if we see the resident bump into something." The staff further indicated, they observed the resident going through the fire doors, to go smoke, and as passing through the staff observed the resident bumped their arm against the door. Staff P reported, the resident said they didn't get hurt. The aide further indicated observing the resident with a new bruise to their arm, which the resident indicated had been caused by a new watch.

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On 4/30/12 at 4:03 PM, direct care staff S, reported the resident required occasional assistance with transfers, although generally independent with ADL's. The staff reported knowledge of reporting bruising to the charge nurse, and felt the resident often bumped into things while self propelling the wheel chair, about the facility.

The interdisciplinary progress notes, dated 4/30/12 at 7:19 PM, evidenced documentation, "A bruise to the right wrist noted, resident stated, 'It's from my watch. I am going to have someone adjust the links on it'." The progress notes lacked further documentation of bruising for the previous 30 days."

The facility Care Planning Policy, revised 12/08, identified, "The Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident."

The facility failed to develop an individualized, comprehensive plan of care for this resident, identified with a history of bruising, to prevent further bruising to this resident with bruises.

- The facility admitted resident #49 on 11/2/2011, with diagnoses including: bladder disorder, rheumatoid arthritis, abnormal weight loss, hypertension, heart failure, venous thrombosis, COPD (chronic obstructive pulmonary disease), esophageal reflux, vitamin deficiency, depressive disorder, acute pain, and with a stage IV decubitus ulcer to the coccyx.

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The resident's quarterly 1/1/12 MDS, identified the resident cognitively intact, with a BIMS score at 14, and continued to identify the presence of a stage IV pressure ulcer present on admission.

The 11/9/11 care plan, instructed staff, "Vitamin C and vitamin D daily. Med Pass (a nutritional supplement). To monitor my pressure ulcer and treat, as indicated. Reposition the resident every 2 to 3 hours and prn (as needed), for comfort and physical support, staying off the back as much as possible, to relieve pressure on the coccyx." The care plan lacked an intervention to provide the resident with an adequate pressure relieving device to the resident's wheelchair, to promote healing of a pressure ulcer the resident admitted to the facility with.

The resident's Braden Scale for Prediction of Pressure Sore Risk, dated 3/25/12, identified the resident scored 19, indicating, "Not at risk." The interventions noted to the assessment included pressure relieving devices for chair and bed, and a turning and repositioning program. However, interview with administrative nursing staff C, on 5/1/12 at 8:25 AM, reported the Braden skin assessment, as documented, contained inaccurate information because, "The resident did not walk frequently and had more than a potential for friction/ shearing." The staff member corrected the inaccurate assessment.

On 4/30/12 at 8:08 AM, observation identified the resident transferred to bed, following breakfast in the main dining room. Direct care staff P, transferred the resident from a wheel chair, with a cloth covered, 2-3 inch thick foam cushion to the chair seat.

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Interview with direct care staff P, on 4/30/12 at 10:40 AM, reported the resident required repositioning frequently from side to side only, used an air bed, transferred with 2 staff, and a gait belt, and mobile in a wheel chair via staff assistance.

At 11:31 AM on 4/30/12, direct care staff P and Q, assisted the resident out of bed for lunch. Prior to the transfer, conversation with the resident, revealed the foam cushion, in the wheel chair seat, belonged to the facility and the resident's family planned to purchase a gel cushion for the resident. During examination of the cushion, surveyor AA squeezed the foam seat cushion between their thumb and fingers, and compressed the cushion to less than 1 inch of cushion (pressure relieving ability) available. The staff continued with the transfer, then propelled the resident in the wheel chair to the dining room and pushed the resident's wheel chair up to a dining table. Throughout lunch the resident remained in the wheel chair, with an inadequate pressure relieving device, in place.

On 4/30/12 at 4:08 PM, direct care staff S, reported the resident required total care, however, communicated their needs. The staff reported the resident with a pressure sore and used an air bed and a foam cushion in their wheel chair. The staff reported the resident enjoyed staying up during the evening shift, after supper, in the wheel chair, as the resident chose to smoke at 7:15 PM with the staff. The staff further indicated the resident typically got out of bed, for supper, about 4:30 PM. Therefore, the resident routinely sat on the inadequate cushion, from

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4:30 PM until 7:30 PM, for at least 3 hours.

On 5/1/12 at 3:30 PM, interview with administrative nursing staff A, indicated a lack of awareness of the presence of only a foam cushion to the resident's wheel chair, and reported the resident needed a gel cushion, for adequate pressure relief.

The facility, Care Planning Policy, revised 12/08, identified "The Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident."

The facility failed to develop a comprehensive plan of care to include the use of an adequate pressure relieving device in the resident's wheelchair to promote healing of the resident's pressure ulcer.

- The facility admitted resident #43 on 11/17/10, with diagnoses including: iron deficiency anemia, and respiratory disease with bronchitis. Additional diagnoses, noted to the resident's physician's orders, dated 3/6/12, included: skin disorders, allergic rhinitis, cataract, neuropathy, esophageal reflux, insomnia, hypertension, COPD (chronic obstructive pulmonary disease), anxiety, depressive disorder, chronic pain, Type II diabetes mellitus, and vitamin deficiency.

The quarterly MDS (minimum data set) assessment, dated 4/20/12, identified the resident with a BIMS (brief interview of mental status) of 15, indicating the resident cognitively intact, received (and/or staff offered) PRN (as needed)

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pain medications, and indicated the resident with frequent pain, making it difficult to sleep at night and limited the resident's day to day activities. The assessment further described the pain as moderate in intensity.

The 2/1/12 care plan instructed staff, "Monitor for presence of pain/intolerance during grooming. Has Neurontin/Ultram and Tylenol per order. Monitor for effectiveness. Sees [physician] for neuropathic pain relief." However, the care plan lacked any interventions to instruct the staff in non-pharmalogical interventions for the resident's pain.

On 4/25/2012 at 3:30 PM the resident reported, "I have a lot of neuorpathy pain, but with the COPD, I can't do narcotics. They do the best they can for me."

Direct care staff P, on 4/30/12 at 1:55 PM, reported the resident as mostly independent with cares, but when the resident had complaints of pain, the staff member would notify the charge nurse.

Interview, on 4/30/12 at 4:25 PM with licensed nursing staff O, reported the licensed staff assess any resident with complaints of pain, before medications are given. Additionally, the staff should always try other methods of pain relief, such as repositioning, heat/cold packs, etc. prior to as needed pain medication administration.

The facility, Care Planning Policy, revised 12/08, identified "The Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each

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resident."

The facility failed to develop an individualized plan of care for this resident, with chronic pain, to instruct staff in alternate measures of pain relief, other than medication administration.

- The medical record of resident #34, documented the resident admitted on 12/14/11 with the following diagnoses: malaise and fatigue, edema, rhinitis, allergic, keratosis, actinic; insomnia, unspecified malignant neoplasm other/face, hypothyroidism, vitamin deficiency, hyperlipidemia, Alzheimer's, hypertension, and benign neoplasm of skin (ear and external auditory canal).

The admission MDS 3.0 (minimum data set) with a date of 12/20/12, revealed the resident had a BIMS (brief interview of mental status) score of 3 severely impaired cognition. The resident without any delirium, mood or psychosis noted behavioral symptoms noted.

The 90 day MDS 3.0 (minimum data set) with a date of 3/13/12, revealed the resident had a BIMS (brief interview of mental status) score of 2/15 severely impaired cognition. The resident with no delirium or mood, delusions noted, physical behavior noted 1-3 days, no rejection of care, wandering daily.

The resident's care plan for cognition, reviewed 3/25/12, instructed staff. " Wander daily, monitor and encourage rest as needed." However, the plan of care lacked interventions to address the resident's behaviors related to resistive to care

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and yelling out.

The resident's behavior monitoring by staff from 12/14/11 through 1/13/12, documented the resident yells at staff, wanders at least everyday, refusal of care 1 time on 12/28/11.

The resident's behavior monitoring by staff from 1/1/12 through 1/31/12, documented the resident with wandering.

The resident's behavior monitoring by staff from 2/1/12 through 3/1/12, documented the resident with frequent wandering, no refusal of care and yelling at staff.

The resident's behavior monitoring by staff from 3/1/12 through 3/31/12, documented the resident with behavior monitoring for physical abuse noted-4 times this month on 2-10.; refuses care, 1 time on 2-10 shift; and the resident documented with wandering almost everyday.

The resident's behavior monitoring by staff from 4/1/12 though 4/30/12, documented the resident refuses care, wandering every day, and yells at staff.

On 4/30/12 at 8:30 A. M., the resident ambulating in the hallway by self, in a pleasant mood.

On 4/30/12 at 8:45 A. M., direct care staff M preceded to ambulate with the resident to the activity room for group exercises. No resistance to care, yelling and/or physical abuse noted.

On 4/30/12 at 10:15 A. M., the resident drinking a 180 cc (cubic centimeters) of juice from the

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hydration cart, smiling, no behaviors noted.

3:00 PM, the resident ambulating in the hallway, gait steady. No s/s of behavior noted.

4:00 P. M., the resident stands up from sitting position without difficulty with balance. Then ambulates down the hall, gait steady. No physical behavior noted toward residents or staff.

5/1/12 at 7:30 AM, the resident without behaviors noted. wandering the hallway by self.

On 4/30/12 at 9:00 A. M., direct care staff M reported, "The resident wanders the halls a lot. He/She doesn't yell or resist care for me."

On 4/30/12 at 3:15 P .M., direct care staff N reported, "The resident gets a little " grumpy" when it is time for bed. He/she doesn't want to be separated from his/her (gender) friend he/she walks with. The resident has never been physically abusive to me."

On 5/1/12 at 8:25 A.M., direct care staff M reported, " The resident tried to kind of slap at me, not hard or anything, when I tried to shave him/her. I told the nurse then documented on the behavior sheet the resident physically aggressive. Does not give intervention or results of intervention we just check it."

The facility policy dated 2001, revised April 2007, for Behavior and Assessment Monitoring, documented the following;..."Monitoring...2.) The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about

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F 279	Continued From page 17 specific problem behaviors: a. Number and frequency of episodes; b. Preceding or precipitating factors; c. Interventions attempted (if psychoactive drug is used as a intervention, institute appropriate psychoactive drug monitoring); and d. Outcomes associated with interventions." On 5/1/12 at 1:50 P. M., administrative nursing staff C reported, " The ADL book with has the residents behavior sheet. They mark for wandering, yelling or physical abuse. I don't have a place for intervention. I don't see a care plan for behaviors." On 5/1/12 at 1:50 P. M., administrative nursing staff B reported, "The resident with behaviors. They are better now. I don't know what is on the care plan." Furthermore, the resident's Urinary Incontinence Assessment, dated 12/14/11, documented the resident with prior history of incontinence. Unsure of duration and prior characteristics. No current or persistent UTI's. The resident is frequently incontinent. (7 episodes of urinary incontinence, but at least one episode of continent voiding). The resident taking narcotics. May cause urinary retention or overflow incontinence. The resident does not use urinary tract stimulants or irritants such as frequent caffeine intake. No complications such as decreased or increased urine output. The resident function and cognitive capabilities document, decreased lower extremity muscle strength, impaired cognitive function, impaired mobility, extensive assistance for	F 279		

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toileting of 1 staff. The resident sometimes recognizes the need to void and in the appropriate place. No contributing factors that could affect the urinary tract or its function. Cognitive skills for decision making moderately impaired. The resident does have a skin breakdown. (admitted with). No labs to review at this time. The resident uses bed rails for mobility. EVALUATION: none marked. INTERVENTIONS: absorbent products, skin management. Referrals to occupational and physical therapy. INITIATE PLAN OF CARE.

The residents three day void pattern/voiding record, dated 12/15-17/11, documented the resident incontinent of urine at 8 A. M., (12/15/11) and 5 P.M., (12/15/11). On 12/16/11 the resident incontinent of urine at 6:00 A. M., and 9 P. M. The resident documented as continent of urine on the 12/17/11. The pattern shows the resident voided on the 15th every 3-4 hours, on the 16th the resident went 8 hours before voiding, then went every 2 hours. On the 17th, the resident voided erratically. The results of patterns is prompt and assist with toileting every 2-3 hours.

The admission MDS 3.0 (minimum data set) with a date of 12/20/11 documented the resident had a BIMS (brief interview of mental status) score of 5, cognition severely impaired. The resident's ADL's documented the following: transfers, toilet use, and personal hygiene required extensive staff assist of 1. Balance during transitions the resident required staff assistance to move from seated to standing, turning around and facing the opposite direction, moving off/on the toilet. The resident not steady when walking but able to stabilize without help, and used a walker. The

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resident on a toileting plan which resulted in decreased wetness. The resident is occasionally incontinent of urine.

The CAAS (care area assessment), dated 12/20/11, documented for urinary incontinence, the resident has episodes of urinary incontinence.

The care plan for urinary incontinence, dated 12/26/11, instructed staff to prompt and assist me with toileting every 2-3 hours and prn. Provide me with incontinence care after each incontinent episode. However, the plan of care lacked an individualized toileting plan for this resident.

The 90 day MDS 3.0 (minimum data set) with a date of 3/13/12 revealed the resident had a BIMS (brief interview of mental status) score of 5 severely impaired cognition. The resident required extensive assistance of 1 for transfers, toileting and personal hygiene. The resident frequently incontinent of urine.

On 4/30/12 at 8:45 A.M., the resident toileted self in hallway shower room. direct care staff M encouraged the resident to wash/dry hands. Then proceeded to ambulate with the resident to the activity room for group exercises.

On 4/30/12 at 9:00 A.M., direct care staff M reported the resident does take himself to the bathroom. He is not always continent of urine. We encourage him/her to go to the bathroom about every 2 hours. We change his/her briefs and give him/her peri care.

On 4/30/12 at 11:00 A.M., the resident ambulated from his/her room, to the bathroom across the

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hall and toileted self. direct care staff M, went in to the bathroom, to see if the resident required assistance. The resident encouraged to wash/dry hands.

On 4/30/12 at 3:10 P.M., direct care staff N reported, "The resident is incontinent of urine, sometimes bowel. Wears pull up briefs. We change him/her before he/she goes to bed, he/she likes to go to bed early around 6-7 P. M., we have to make sure we change him/her before he/she goes to sleep."

On 5/1/12 at 8:25 A.M., direct care staff M, assisted the resident to the bathroom. The resident reported no need to go to the bathroom and staff M failed to check the resident's incontinent brief.

On 5/1/12 at 8:25 A.M., direct care staff M reported, "No need to check the residents brief. Checked him/her this morning. He/She will stay dry all day."

On 5/1/12 at 2:15 P.M., administrative staff C reported, "The resident had been ill when he/she came in. I didn't realize he/she was better. I guess I might need to do another 3 day voiding pattern. We don't do individualized care plans for toileting."

On 5/1/12 at 2:20 P.M., administrative staff B reported, "We will reevaluate the resident's care plan."

Also, the resident's physician orders dated 12/14/11, documented the resident taking Aspirin

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Child Chewable, 81 mg (milligrams), 1 by mouth, daily and Plavix 75 mg, 1 by mouth daily, which can cause the resident to bruise easily.

The admission MDS 3.0 (minimum data set) with a date of 12/20/11, revealed the resident with a BIMS (brief interview of mental status) score of 5, indicating cognition severely impaired, without any behavioral symptoms. The resident's ADL's documented the following: bed mobility, transfers, walk in room, walk in corridor, locomotion on/off the unit, dressing, toilet use, and personal hygiene required extensive staff assistance of 1, used a walker for mobility. No fall history on admission or since admission.

The care plan, dated 3/25/12, lacked any interventions to prevent further bruises to the resident's skin.

The weekly skin assessments for April 2012:

On 4/5/12, "No open areas at this time.

On 4/12/12, red discoloration on top of hands bilaterally.

On 4/19/12, No change.

On 4/26/12, The forehead has small scratches due to recent fall on 4/24/12."

On 4/25/2012 11:34 A.M., observation revealed the resident with abrasions on the left upper forehead, 2 cm (centimeters) in length and vary in width, the area lightly ecchymotic, and healing, no swelling or signs of infection. Light ecchymotic

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areas noted on dorsum right hand.

On 4/30/12, 8:30 A.M., observed the resident with slight discoloration to the forehead in left upper quadrant, and the abrasion is fading along with bruising noted to the residents right hand.

On 4/30/12 at 3:10 P.M., licensed nursing staff O reported, " They don't always do incident/investigations on a bruise. Sometimes the resident's ambulate on their own and just bump into things. If it is a bad bruise then of course I will investigate."

On 4/30/12 at 3:15 P.M., direct care staff N reported, " If I see a bruise I notify the nurse. Then the nurse takes it from there."

5/1/12 at 8:25 A.M., direct care staff M, pulled the residents sleeves of shirt up and revealed the resident with multiple bruised areas, in different stages of healing. No no signs or symptoms of pain or discomfort.

On 5/1/12 at 8:25 A.M., direct care staff M reported, "The resident usually does have bruises. I let the nurse know, and fill out the skin sheet."

On 5/1/12 at 1:55 P. M., administrative nursing staff B reported, "If the resident can not tell me how they got a bruise then I will investigate."

On 5/1/12 at 2:00 P. M., administrative nursing staff C reported, "I know that Plavix and aspirin

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F 279	Continued From page 23 can cause bruising I don't why I didn't care plan this." The facility failed to develop interventions on the resident's plan of care to instruct staff on; what to do when the resident would become resistive to cares or yell out; for an individualized toileting plan; and to prevent further bruising to the resident's skin. - The medical record of resident # 4 documented admission to the facility on 07/29/2009, with the following diagnoses including; constipation, hyperlipedimia, congestive heart failure, osteoarthritis, hypertension, esophogeal reflux, anemia, cardiovascular disorder, depression, angina pectoris, anemia, vitamin B deficiency, rheumatoid arthritis, hypercholesterolemia, anxiety, backache, chronic airway obstruction, edema, coronary disease, and chronic pain. The Annual MDS, dated 2-15-2012, with a BIMS (brief interview of mental status) of 15 (cognitively intact), resident required limited assistance with bed mobility, transfers, ambulation and dressing, independent with eating, with limited range of motion to the upper and lower extremities bilaterally, and with pain indicated. The 5/1/12 care plan failed to address activities that the resident enjoyed. Observation on 4-30-12 at 2 p.m.,revealed the resident assisted with the bingo activity.	F 279		

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Observation on 5-1-12, during the morning hours, revealed the resident watched TV in his/her room.

Interview with the resident on 5-1-12, evidenced that he/she enjoyed the facility activities during the day, but would like to be more involved in the evening activities.

Activity staff D on 4-30-12, stated the resident liked to do his/her own thing in the evening. "He/she is a big sports fan, especially KU basketball games. He/she enjoys helping with the activities sometimes. His/her daughter comes and gets him/her in the evening and he/she used to go dancing but his/her arthritis has gotten worse and he/she likes to watch TV in the evening and just do his/her own thing."

Facility policy for care planning, dated December 2008, documented "The facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident."

The facility failed to develop an individualized care plan for activity preference for this resident.

- Record review revealed resident #37 admitted on 09/25/2009. Physician order sheet for April 2012, documented diagnoses of Alzheimer's, dementia, anxiety, depressive disorder, esophageal reflux, generalized pain, and upper respiratory disease (COPD - chronic obstructive pulmonary disease). A physician order dated 1/12/2012, revealed the resident was admitted to hospice services for diagnoses of Alzheimer's, and COPD (Chronic Obstructive Pulmonary

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F 279	Continued From page 25 Disease). The annual MDS (minimum data set assessment), dated 3/9/2012, documented severe cognitive impairment, the resident required total assistance of 1 staff for bed mobility, personal hygiene, and extensive assistance of 2 staff for transfers, walk in their room, toileting, and dressing. Additionally, the MDS identified the resident received Hospice services. Interview, on 4/30/2012 at 10:00 am, with administrative nursing staff C verified hospice attended one care plan meeting. Administrative nursing staff C stated that hospice staff report findings and concerns to the charge nurse after each visit to the resident. review of the resident's hospice care plan, located in the separate hospice chart, located at the nurses station, dated 1/12/2012, revealed ..." Resident to receive a shower by hospice staff CNA (certified nurse aide) twice a week, and a visit by the hospice staff nurse once a week." Furthermore hospice to provide the resident with oxygen concentrator, and supplies. Review of the resident's care plan dated 3/20/2012, developed by the facility, revealed one hospice intervention for ADL (activities of daily living) care plan under interventions, " Hospice to provide 2 baths a week." The facility Policy and Procedure's for care planning with revision date of December 2008, revealed "Our facility's care planning/interdisciplinary team is responsible for the development of an individualized	F 279		

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F 279	Continued From page 26 comprehensive care plan for each resident." The facility failed to develop a comprehensive care plan that directed the facility staff and the hospice staff on how to coordinate care and services that are to be provided for this resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents with 14 selected for review, which included 3 for accidents. Based on observation, record review and interview, the facility failed to review and revise the care plan for one (#34) of 3 residents	F 280		

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reviewed for accidents.

Findings included;

- The medical record of resident #34, documented admission on 12/14/11, with the following diagnoses: malaise and fatigue, edema, rhinitis, allergic, keratosis, actini,; insomnia, unspecified malignant neoplasm other/face, hypothyroidism, vitamin deficiency, hyperlipidemia, Alzheimer's, hypertension, and benign neoplasm of skin (ear and external auditory canal).

A Fall Risk Assessment, dated 12/14/12, documented a score of 12, indicating high risk for falls.

The admission MDS 3.0 (minimum data set) with date of 12/20/11, revealed the resident with a BIMS (brief interview of mental status) score of 5, indicating cognition severely impaired . The resident without any behavioral symptoms. The resident ADL's (activities of daily living), the following: transfers, walk in room, walk in corridor, locomotion on/off the unit, dressing, toilet use, and personal hygiene required extensive staff assistance of 1. Balance during transitions the resident required staff assistance to move from seated to standing, turning around and facing the opposite direction, moving off/on the toilet. The resident not steady when walking but able to stabilize without help, and used a walker. The resident is occasionally incontinent of urine. Shortness of breath noted on exertion and also with a fever. No falls history on admission or since admission.

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F 280	Continued From page 28 The CAAS (care area assessment) dated 12/20/11,documented for cognition documented the resident with memory recall problem and diagnosis of Alzheimer's disease. The CAAS for falls documented the resident required staff assistance with ADL's. The quarterly MDS 3.0 (minimum data set) with a date of 2/13/12 revealed the resident had a BIMS (brief interview of mental status) score of 3, indicating cognition severely impaired. The resident without behavioral issues. The resident's ADL's documented the following: bed mobility, transfers, and personal hygiene limited staff assistance of 1; walk in room, walk in corridor and locomotion on unit independent; locomotion off unit, supervision with set up assistance, and toilet use extensive staff assistance of 1. Balance during transitions, not steady, able to stabilize self during moving from seated to standing. Used a walker and frequently incontinent of urine. No shortness of breath. One fall since admission, non injury. The care plan for falls dated 12/26/12, documented "I will remain fall free while receiving assistance with ADL's and transfers for the next 90 days. Encourage me not to transfer without assistance. Keep me call light within reach at all times. Encourage rest periods between activities. Ensure I have on shoes or non-skid socks when transferring and ambulating. Keep my room free of clutter. Encourage me to use grab bars in my bathroom to assist with transfers. I require assistance with my ADL's and transfers." On 12/28/11, care plan revised to include, "I have a body alarm in place. I will take alarm off.	F 280		

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Encourage me to ask for assistance with ADL's." On 12/28/11, the care plan revised to include, "I have a walker in my room, assist me with ambulation. Undated revision on care plan documented the resident holding hand with another resident. Ensure the resident stay's in a safe area's and encourage rest as needed."

The nurses notes dated 2/5/12 at 3:20 PM, called to the residents room, and upon entering the room noted the resident lying on back, on the floor. Resident stated, " I started to get up and my feet slipped and down I went" Denies injuries and is moving extremities WNL. No internal external rotation or shortening of limb. Head to toe assessment completed. INTERVENTION: Alert staff that resident is to have shoes on when not in bed. The physician, family and doctor notified. The care plan lacked documentation of an intervention related to this fall.

On 3/30/12 the nurses notes documented the following; the time of fall at 1:00 P. M., the resident with a skin tear to bilateral elbows, 3 cm(centimeters) on the right elbow, and 2 cm on the left elbow. The resident heard calling out and found on abdomen, resting on elbows on the floor of his/her room. Reports that tripped over his/her feet and landed on his/her knees and elbows. Denies striking head. Resident has experienced occasional confusion, but is alert and oriented when relating this event. Knees are noted to have pink areas. The family and doctor notified. The care plan lacked documentation of an intervention related to this fall.

On 4/24/12, per nurses notes, documented, around 9:00 A. M. "... the resident outside in the

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garden area walking across a grass area. Staff went out to bring the resident in, as they entered the garden, the resident tripped and fell. The nurse on duty alerted. Staff stayed with the resident til the nurse came out. After the resident checked him out we assisted him to his feet and walked him inside the building. Neuro checks initiated, and the family and doctor notified. The care plan lacked documentation of an intervention related to this fall.

On 4/30/12 at 8:00 AM, the resident ambulating in the hall, by self, gait steady.

On 4/30/12 at 8:45 AM, the resident toileted self in hallway shower room, direct care staff M encouraged the resident to wash/dry hands. Then preceded to ambulate with the resident to the activity room for group exercise. The residents gait is steady.

On 4/30/12 at 10:45 AM, the resident assisting the activity director, delivering calendars, gait steady.

On 4/30/12 at 11:45 AM, the resident ambulating to the dining room with staff, gait steady

On 4/30/12 at 1:00 PM, the resident toileting self, washed/dried hands gait steady.

On 4/30/12 at 3:00 PM, the resident ambulating in the hallway, gait steady.

On 4/30/12 at 4:00 PM, the resident stands up from sitting position without difficulty with a steady balance. Then ambulates down the hall, gait steady.

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F 280	Continued From page 31 On 4/30/12 at 4:30 PM, the resident walking in the hallway, gait steady. On 5/1/12 at 9:00 AM, the resident ambulating ad lib in the hallway. On 4/30/12 at 9:00 AM, direct care staff M reported, "The resident ambulates on his own. The resident will wander all over the facility, used to use a walker but not anymore, would leave it or pick it up and carry it, which was more dangerous. We try to get him/her to rest for a little while by sitting him/her in his/her recliner, and covering him/her with a blanket. He/She will usually rest for about 30 minutes." On 4/30/12 at 3:15 PM, direct care staff N reported, "the resident ambulates by self, used to have a walker, did not use it right. His/her gait is usually steady." 4/30/12 at 9:00 AM, licensed nursing staff O, reported the resident recently had a fall. Then notified the doctor and family. I leave place an intervention in the nurses notes. they decide if they are going to use it." On 5/1/12 at 1:33 PM, administrative nursing staff B reported, " I don't have an intervention in place yet (referring to the fall dated 4/24/12), do to. There is a post fall observation (assessment) they are to do now, when ever they have a fall. The resident fell in his room around a month ago, we thought to add to wear non skid socks, and shoes, did not realize this intervention is already on the care plan.".	F 280		

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F 280	Continued From page 32 On 5/1/12 1:45 PM, administrative nursing staff C reported, " No interventions except to keep the resident safe. We took away the walker. I guess we didn't up date the care plan." The facility policy, Revised April 2010, documented, "All accidents or incidents involving resident, employees, visitors, vendors, etc., occuring on our premises shall be investigated and reported to the Administrator." The facility failed to review and revise the resident's care plan to ensure the resident free of accidents.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents with 14 residents selected for sample review. The facility identified 1 resident with pressure ulcers included in the sample. Based on observation, interview, and record review, the facility failed to provide care and services to promote healing of a pressure ulcer for 1 of 1 resident, # 49, reviewed for pressure ulcers.	F 314		

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Findings included:

- The facility admitted resident #49 on 11/2/2011, with diagnoses including: bladder disorder, rheumatoid arthritis, abnormal weight loss, hypertension, heart failure, venous thrombosis, COPD (chronic obstructive pulmonary disease), esophageal reflux, vitamin deficiency, depressive disorder, acute pain, and with a stage IV pressure ulcer to the coccyx.

The resident's 11/8/11, admission MDS (minimum data set), identified the resident as cognitively intact with a BIMS (brief interview of mental status) score of 14, required extensive assistance of 2 staff for bed mobility and transfers, and identified the resident admitted with a stage IV pressure ulcer, which measured at 10.5 cm (centimeters) length by 7 cm width by 5 cm depth.

The CAA's (care area assessment), dated 11/9/11, identified the triggered nutritional status required care planning, related to, "[The] resident has open wounds. Has diagnosis of malnutrition and receives Marinol daily." Additionally, the the care area of pressure ulcer triggered, related to the assessment, documented, "Has pre-existing [pressure ulcer] and is at risk for pressure ulcers."

The resident's quarterly 1/1/12 MDS, identified the resident's BIMS score at 14, and continued to identify the presence of a stage IV pressure ulcer present on admission.

The 11/9/11 care plan, instructed staff, "Vitamin C and vitamin D daily. Med Pass (a nutritional

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supplement). To monitor my pressure ulcer and treat, as indicated. Reposition the resident every 2 to 3 hours and prn (as needed), for comfort and physical support, staying off the back as much as possible, to relieve pressure on the coccyx." The care plan failed to identify the use of a pressure relieving chair cushion or pressure relieving mattress to the bed surface, to promote healing of the pressure ulcer.

The resident's nutritional assessment, dated 3/16/12, conclusion noted, "Resident continues on regular Medpass 90 cc (cubic centimeters), TID (three times daily). Weight is up 11.1% in 95 days to 152.6#. IBW (Ideal body weight) is 128-156#. Continues [with] treatment to pressure ulcer on coccyx. Albumin lab from 2/1/12 was low at 2.9. Due to a significant weight gain and [the] resident being within IBW range, recommend to decrease Med Pass to 60 cc BID (twice daily). For wound healing, recommend: 1.) Beginning a daily MVI (multivitamin with minerals. 2.) 220 mg (milligrams) zinc sulfate daily for 14 days. 3.) Increase Vitamin C to 500 mg daily for 14 days and 4) 4-6 ounces of OJ (orange juice) or Vitamin C fortified juice bid."

The resident's Braden Scale for Prediction of Pressure Sore Risk, dated 3/25/12, identified the resident scored 19, indicating, "Not at risk." The interventions noted to the assessment included pressure relieving devices for chair and bed, and a turning and repositioning program. However, interview with administrative nursing staff C, on 5/1/12 at 8:25 AM, reported the Braden skin assessment, as documented, contained inaccurate information because, "The resident did not walk frequently and had more than a potential

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for friction/ shearing." The staff member corrected the inaccurate assessment.

On 4/30/12 at 8:08 AM, observation identified the resident transferred to bed, following breakfast in the main dining room. Direct care staff P, transferred the resident from a wheel chair, with a cloth covered, 2-3 inch thick foam cushion to the chair seat.

Interview with direct care staff P, on 4/30/12 at 10:40 AM, reported the resident required repositioning frequently from side to side only, used an air bed, transferred with 2 staff, and a gait belt, and is mobile in a wheel chair via staff assistance.

At 11:31 AM on 4/30/12 direct care staff P and Q, assisted the resident out of bed for lunch. Prior to the transfer, conversation with the resident, revealed the foam cushion, in the wheel chair seat, belonged to the facility and the resident's family planned to purchase a gel cushion for the resident. During examination of the cushion, the surveyor squeezed the foam between their thumb and fingers, and compressed the cushion to less than 1 inch of cushion available. The staff continued with the transfer, then propelled the resident in the wheel chair to the dining room and pushed the resident's wheel chair up to a dining table. Throughout lunch the resident remained in the wheel chair, with an inadequate pressure relieving device, in place.

On 4/30/12 at 4:08 PM, direct care staff S, reported the resident required total care, however, communicated their needs. The staff reported the resident with a pressure sore and

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used an air bed and a foam cushion in their wheel chair. The staff reported the resident enjoyed staying up during the evening shift, after supper, in the wheel chair, as the resident chose to smoke at 7:15 PM with the staff. The staff further indicated the resident typically got out of bed, for supper, about 4:30 PM. Therefore, the resident routinely sat on the inadequate cushion, from 4:30 PM until 7:30 PM, for at least 3 hours.

On 4/30/12 at 4:25 PM, direct care staff R and S, assisted the resident out of bed for supper. The staff transferred the resident into a wheel chair, with a foam cushion to the seat of the wheel chair.

Observation on 5/1/12 at 1:30 PM, revealed licensed nursing staff F completed a dressing change to the resident's coccyx wound. The wound presented as a healing stage IV, measuring approximately 3 cm (length) by 4 cm (width) by 1 cm (depth) a beefy red center. The wound lacked odor or drainage.

On 5/1/12 at 3:30 PM, interview with administrative nursing staff A, indicated a lack of awareness of the presence of only a foam cushion to the resident's wheel chair, and reported the resident needed a gel cushion, for adequate pressure relief.

The 2004 United States Department of Health and Human Services, Public Health Service Agency for Health Care Policy and Research, Pressure Ulcer Treatment, Clinical Practice Guideline #15, identified, "Staff should ...use positioning devices to raise the pressure ulcer off the support surface..."

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F 314	Continued From page 37 The facility failed to provide this resident with an appropriate pressure relieving cushion to the wheel chair, to promote healing of the pressure ulcer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents with a sample of 14 residents. Based on observation, staff interview, and record review, the facility failed to provide an individualized toileting program for 1 resident (#6) of 2 residents sampled, for incontinence/toileting needs. Findings included: - The medical record of resident # 6, admitted on 12/02/2004, with the following diagnoses including dementia without behavior disturbance, constipation, generalized pain, hypercholesterolemia, muscle/ligament disorder, allergies, osteoporosis, coronary artery anomaly, hypothyroidism, vitamin B12 deficiency anemia,	F 315		

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depression, hypertension, cardiovascular disease, hemiplegia, atherosclerosis, female stress incontinence and esophageal reflux.

The Annual MDS (minimun data set), dated 4-3-12, documented a BIMS (brief interview of mental status) of 1 (indicating severe impairment). The resident required total dependence with 2 staff's assistance for bed mobility, transfers,and toileting. He/she required total dependence with one staff for personal hygiene and dressing. Functional limitation is impairment on both sides. He/she had a trial of a toileting program, no improvement and no current toileting program. The resident is always incontinent of bladder and frequently incontinent of bowel.

The urinary CAA's (Care area assessment), dated 4-16-12, documented,"Toilet use self-performance is indicated." The summary documented, "Incontinent of bowel and bladder and at risk for skin breakdown."

The care plan dated 4-16-12, included "Provide incontinence care after each incontinent episode. Offer/prompt toileting every 2-3 hours and prn (as needed) while awake. Check and change every 2-3 hours and prn at hours of sleep. Use pull-up briefs daily while awake."

The physician order sheet dated 11-1-2008, documented the resident is on a toileting program of check and change every 2-3 hours and to provide incontient care.

The monthly summary dated 4-4-2012, documented the resident needs total dependence

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for toilet use and he/she is incontinent of bowel and bladder. He/she uses pad/briefs for incontinence and does not use the toilet or commode.

The resident's 3-day voiding pattern dated 3-29-12 thru 3-31-12, evidenced the resident is changed every 2 hours by staff. Program states that resident will be a check and change program every 2-3 hours and to provide incontinent care.

Observation on 4-30-12 at 4:35p.m. revealed direct care staff N and S assisted the resident up for supper. The resident's brief observed wet with urine. The staff failed to offer him/her the opportunity to toilet at this time.

Observation on 5-1-12 at 10:16 a.m. reavealed direct care staff M assisted the resident to bed after breakfast. The resident's brief observed wet with urine. The staff failed to offer him/her the opportunity to toilet at this time.

Interview on 4-30-12 at 4:22 p.m. direct care staff N states that resident is checked and changed every 2 hours, but if he/she requests to have a bowel movement the staff assist him/her to the toilet.

Interview with Licensed nursing staff F on 5-1-12 at 7:58 a.m states that he/she is on a scheduled toileting program every two hours and he/she is assisted to the toilet.

Interview with administritive nursing staff C on 5-1-12 at 8:09 a.m. states that he/she is in charge of the toileting program."When the resident is admitted, a 3 day voiding pattern is put out for

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F 315	Continued From page 40 direct staff, then when the assessment is done, he/she looks at the 3 day pattern and interviews staff, he/she creates a toileting program and prints out a general order and places it in the ADL book for the direct staff, and then reassesses the program with MDS assessments quarterly." The facility policy for urinary continence and incontinence, dated October 2010, documented the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence, the physician and staff will provide appropriate services to help residents restore or improve bladder function. The facility failed to develop an individualized toileting program to assist with restoring or improving bladder function for this resident.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: The facility identified census of 32 residents with a sample of 14 residents. Based on observation, staff interview, and record review, the facility failed to provide range of motion/splint services to prevent further decline of range of motion for 1 resident (#6) of 2 residents sampled for	F 318		

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restorative services.

- The medical record of resident # 6, admitted on 12/02/2004, with the following diagnoses including dementia without behavior disturbance, constipation, generalized pain, hypercholesterolemia, muscle/ligament disorder, allergies, osteoporosis, coronary artery anomaly, hypothyroidism, vitamin B12 deficiency anemia, depression, hypertension, cardiovascular disease, hemiplegia, atherosclerosis, female stress incontinence and esophageal reflux.

The annual MDS, dated 4-3-12, with a BIMS (brief interview of mental status) with a score of 1 (severe impairment). Resident is total dependence with 2 staff's assist for bed mobility, transfers, toileting. He/she doesn't ambulate. He/she needs total dependence with one staff for eating, locomotion, personal hygiene and dressing. Functional limitation is impairment on both sides. No pain evidenced by resident in the last 5 days. No physical or occupational therapy; resident received 6 days of PROM (passive range of motion) with restorative nursing.

The care plan dated 4-16-12, documented the resident needed extensive assist of 1-2 for dressing, personal hygiene and transfers. Interventions included, "Dress right side first. Resident's [family member] continues to place brace to right hand even though it doesn't fit right." An addition, dated 4-16-12, included "Resident has contractures of the affected right side from CVA [cerebrovascular accident] and muscle weakness. PROM [passive range of motion] daily to all extremities as tolerated by the resident."

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Nurses notes dated 4-8-2012, documented "Restorative nursing program review, Resident participates in range of motion to all extremities daily. Maintaining current range of motion."

The April, 2012, restorative flow sheet documented the resident with potential for decreased range of motion and contracture related to decreased mobility. PROM (passive range of motion) to all extremities daily as tolerated by the resident. The resident received 15 minutes of restorative nursing daily (except for the 8th, 14th, 15th, 21st, 22nd and 29th) in the month of April.

On 5-1-12 at 10:25 a.m, direct care staff K assisted the resident with passive range of motion, to the resident's right hand.

On 5-1-12 at 8:31 a.m., direct care staff K stated Administrative nursing staff C is in charge of the program and he/she follows the restorative book for his/her programs. Staff K stated they have meetings every two weeks, when there is a decline, its just obvious. Staff K stated most programs are set up by therapy and Administrative nursing staff C.

On 5-1-12 at 8:16 a.m., Administrative nursing staff C stated the resident has a restorative program for the right hand but no splint has been done. Physical therapy has not assessed him/her for a program for his/her contracture to his/her right hand.

On 5-1-12 at 6:30 p.m., observed splint to the resident's right hand that did not fit properly.

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F 318	Continued From page 43 The facility policy for restorative services dated December, 2007, documented, "Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments." The facility failed to initiate a restorative program to include the use of a splint, to prevent further decline in the resident's range of motion ability and contractures.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents, with 14 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure 2 of 3 residents, (#5, and 37) selected for review of accidents, received care, treatment, and services to prevent further accidents. Findings included: - The facility admitted resident #5 on 1/9/07, with diagnosis including: multiple sclerosis, depressive disorder, anxiety disorder, vitamin deficiency,	F 323		

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muscle spasm, osteoporosis, pain, stomach function disorder, and eye disorder.

A quarterly, 1/30/12, MDS (minimum data set) identified the resident with a BIMS (brief interview of mental status) of 13, indicating cognitively intact, transferred with limited assistance of 1 staff, and lacked identification of any skin issues.

Review of "The Weekly Skin Assessment Record," dated 4/2012, identified the following:
4/3/12 No new issues to skin noted.
4/10/12 Bruise to right breast, states during self-transfer, no other issues to skin at this time.
4/17/12 healing bruise to right breast, no other issues noted to skin.
4/24/12 No new issues to skin noted.

The resident's care plan, dated 5/11/11, identified the resident received prednisone daily, used a wheel chair independently for mobility, and directed staff to monitor the resident for coordination and weakness, related to MS (multiple sclerosis), identified a history of falls, and self transferring. The care plan lacked direction to staff regarding the prevention of bruising.

The most recent POS (physician order summary), dated 3/6/12, ordered, "Prednisone, 5 mg (milligram), daily, for multiple sclerosis, ordered 8/21/08.

Observation on 4/26/2012 at 9:31 AM, identified multiple, various sized bruised areas to the resident's bilateral arms, and abrasions to the resident's knees. At that time, the resident stated, "I run into things all the time."

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F 323	Continued From page 45 On 4/30/12 9:55 AM observation identified the resident self propelled a wheel chair to the nurses' desk, inquiring regarding smoking. Additional observations, throughout the survey time frame, from 4/25/12 to 5/1/12, identified the resident self propelled their wheel chair throughout the facility. Interview on 4/30/12 at 10:47 AM, with direct care staff P, reported the resident usually independent with ADL's (activities of daily living). Inquiry on the staff's knowledge of procedure for reporting injuries to resident's identified the staff are trained to, "Note on the shower sheets all new bruising and tell the charge nurse daily when see a new area. Or, if we see the resident bump into something." The staff further indicated, they observed the resident going through the fire doors, to go smoke, and as passing through the staff observed the resident bump their arm against the door. The staff reported, the resident said they didn't get hurt. The aide further indicated observing the resident with a new bruise to their arm, which the resident indicated had been caused by a new watch. On 4/30/12 at 4:03 PM, direct care staff S, reported the resident required occasional assistance with transfers, although generally independent with ADL's. The staff reported knowledge of reporting bruising to the charge nurse, and felt the resident often bumped into things while self propelling the wheel chair, about the facility. Review of the clinical electronic interdisciplinary	F 323		

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progress notes, dated 4/30/12 at 7:19 PM, evidenced documentation, "A bruise to the right wrist noted, resident stated, 'It's from my watch. I am going to have someone adjust the links on it'." The progress notes lacked further documentation of bruising for the previous 30 days."

Interview on 5/1/12 at 9:30 AM, administrative nursing staff B, reported the nurses are required to document the size and appearance of bruising on residents when observed.

The facility failed to provide the resident with any preventative interventions, related to the resident's continued accidents with multiple bruises/abrasions.

- Resident # 37 admitted to the facility on 09/25/2009, with a readmission date of 12/26/201, with diagnosis of Alzheimer's, esophageal reflux, generalized pain, debility, convalescence, and upper respiratory disease.

The Annual MD'S (minimum data set assessment) dated 3/9/2012, documented severe cognitive impairment, the resident required total assistance of 1 staff for bed mobility, personal hygiene, and required extensive assistance of 2 staff for transfers, walking in their room, toileting, and dressing.

Review of the resident's care plan dated 3/20/201, identified on his/her ADL's (activities of daily living) care plan that hospice provided showers 2 x weekly, staff provided 1 x weekly and prn (as needed). Report skin concerns to the nurse.

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F 323	Continued From page 47 Observation on 4/25/2012 at 4:50 pm, revealed a 2 cm (centimeters) diameter round bruise to the top of the resident's left forearm, and also a 2 cm bruise to the left elbow. On 4/30/2012 1:15 pm, direct care staff M stated, "The resident is an 1 person extensive assistance with a gait belt for his/her care, some days are better than others, and he/she cooperates and does more. I was not aware that the resident currently has a bruise. If I did find a bruise, I would report it to the nurse." On 4/30/2012 9:25 am, licensed nurse O stated "If staff report a bruise to me then I will go in and talk to the resident, inspect the bruise, and then measure it. I would then notify the DON (Director of Nursing), she will investigate how it happened, and then we will put new interventions in place as needed." On 4/30/2012 1:55 pm, administrative nursing staff B stated "If staff find a bruise they will notify the charge nurse, she will notify me, then we will investigate it if we do not have a reason for how the bruise occurred. I was not aware that the resident had a bruise, I will investigate it." A nurses note dated 4/30/2012, documented a 3.5 cm (centimeter) x 1.5 cm area that appears to be a bruise noted to the back of the resident's right hand, 1 cm bruise to bicep area on RUE (right upper extremity) also. When asked if the resident knew how these occurred, stated "probably hit my arm on the wheelchair when I got up."	F 323		

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F 323	Continued From page 48 Record review of weekly skin assessments record dated 4/29/2012, documented 1 cm bruise to right bicep, 3.5 cm x 1.5 cm bruise to the right hand. A hospice aide visit note dated 4/29/2012, documented, "Resident showered with no areas of concern identified." The shower body check program record dated 4/30/2012, filled out by the CNA (certified nurse aide) staff when bathing residents, revealed no areas of concerns identified, with the specific question for bruise marked "no" on the assessment record. This record documented signatures by direct care staff M, and by licensed nurse O. Review of the facility Policy and Procedure's revised on April 2010, for Accidents and Incidents, revealed "All accidents or incidents involving residents, employees, visitors, vendors, ect., occurring on our premesis shall be investigated and reported to the Administrator." The facility failed to investigate and implement new interventions for this resident following an accident or incident that caused multiple bruises on the resident's upper extremities, to prevent further accidents, or development of bruises to the resident.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		

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F 325	Continued From page 49 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents with 14 selected for review, which included 2 residents reviewed for nutrition. Based on observation, record review and interview, the facility failed to implement recommendations from the registered dietician for weight loss of one of 2 (#34) resident's reviewed for nutrition. Findings included; - Resident #34 admitted to the facility on 12/14/11, with the following diagnoses including; malaise and fatigue, edema, rhinitis, allergic, keratosis, actinic; insomnia, unspecified malignant neoplasm other/face, hypothyroidism, vitamin deficiency, hyperlipidemia, Alzheimer's, hypertension, and benign neoplasm of skin (ear and external auditory canal). The admission MDS 3.0 (minimum data set) with a date of 12/20/11, revealed the resident had a BIMS (brief interview of mental status) score of 3 indicating severely impaired cognition. The resident without behaviors. Required supervision for eating. Shortness of breath on exertion and a fever. The resident without a swallowing problem, and no oral problems. The resident weighed 158	F 325		

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pounds. No weight loss noted.

The 90 day MDS 3.0 (minimum data set) with a date of 3/13/12, revealed the resident had a BIMS score of 2 indicating severely impaired cognition. The resident with no rejection of care, wandering daily, and physical behavior 1-3 days. The resident required extensive staff assistance of 1 for eating. The resident with shortness of breath on exertion, sitting, at rest, and lying flat, along with a fever. Documented with coughing or choking during meals or swallowing medication. The resident weighed 137 pounds and marked weight loss. No nutrition approach noted.

The CAAS (care area assessment) summary, dated 12/20/11, documented for nutrition; the resident is at risk for pressure ulcers and impaired skin integrity. The resident cognition CAAS, documented the resident has memory recall problems and a diagnosis of Alzheimers disease.

The resident's care plan, dated 12/26/11, for nutrition included consume meals in assisted dining room, assist me as needed. Offer me hydration cart and snack when available. I like chocolate. Weigh me monthly, and as ordered. Notify me and my family, and PCP (primary care physician) for significant changes in my weight. On 12/28/11, encourage and assist me to drink 2000 cc (cubic centimeters) of fluids per day. On 12/28/11, obtain dietary and pharmacy consult every 2 months. On 1/10/12, I am on a regular pureed food, nectar thickened liquids. The resident's care plan updated, 1/13/12, has had weight loss, weigh weekly, Med Pass 90 cc TID (three times daily).

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The resident's weight on admission, 12/14/11, 158 pounds per the facility weight variance report. The report further documented:
On 1/2/12, 145 pounds per the facility weight variance report, a loss of 13 pounds/8.23% (percent) in less than 30 days.

The clinical record lacked weekly weights documented from 1/14/12 through 2/1/12 as planned.

On 2/1/12, 145 pounds per the facility weight variance report.

On 2/7/12, 142 pounds per the facility weight variance report.

On 2/8/12, 142 pounds per the facility weight variance report.

On 2/15/12, 141 pounds per the facility weight variance report.

On 2/21/12, 140 pounds per the facility weight variance report.

On 2/22/12, 140 pounds per facility weight variance report.

On 3/5/12, 137 pounds, per the facility weight variance report, a loss of 21 pounds/13.29% in less than 3 months.

On 4/3/12, 132 pounds per the facility weight variance report.

On 4/11/12, 134 pounds per the facility weight

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variance report.

On 4/18/12, 134 pounds, per the facility weight variance report, the resident with a 13 pound/8.5% weight loss in less than 30 days.

On 4/25/12, 134 pounds, per the April 2012, MAR (medication administration record).

The resident's weight on 5/2/12, 135 pounds, per the May 2012 MAR.

The resident experienced a total weight loss of 23 pounds/14.5% in less than 5 months.

The clinical record documented the physician notified of the initial loss of 13 pounds, ordered lab, dated 1/3/12,which documented the resident with a hemoglobin of 12.2, low, normal range is 14-17; the hematocrit is 39, low, the normal range is 42-52. The residents albumin level is 3.0, low, normal range is 3.6 to 5.1, with no new orders received from the physician.

A nutritional assessment, dated 1/10/12, documented the resident on a regular diet; height of 67 inches, weight is 145 pounds. The resident's IBW (ideal body weight) is 133-163 pounds, he/she is at goal body weight. The resident has a BMI (body mass index) of 22.7 (within normal acceptable limits). The resident required daily cleaning of dentures, with a chewing and swallowing or nutritional problems. The resident required 1800-2220 cal (calories), 72-89 grams of protein and 1800-2220 cc (cubic centimeters) fluids in a 24 hour day. The resident with a 3 to 5% weight change in 30 days. The

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residents' meal intake meets 26-75% of estimated needs, and consumes 1,500-2,00 cc day. Is taking 5 or more medications daily. The resident with diagnoses of, Alzheimer's, hypertension, edema, hyperlipidemia. Required assist with eating, albumin 3.0-3.4, hemoglobin and hematocrit low on 1/3/12 and the skin is intact. The nutritional risk indicator evaluation the resident scored a 13, (8 or more points-High Risk). No referrals necessary. The plan of care for the resident; admitted on regular diet, diagnosis of swallow/chewing issues noted. ST (speech therapy) consult today. Will await recommendation for appropriate diet. The resident t assisted with eating and appetite reported good recently. Weight is down 8.5% in 19 days. Recommend a 3 day weight check to ensure accuracy. Currently weighed is 145 pounds, ideal body weight for age and height is 133-163 pounds. The residents albumin lab low at 3.0 on 1/3/12. Recommend additional protein by adding an extra egg at breakfast and/or 1 oz extra meat at lunch and dinner.

On 3/16/12 dietary progress notes, documented the following; the resident continues on a pureed diet with nectar thickened liquids and MedPass 90 cc by mouth TID. Weight is down 3.8% in 33 days to 137 pounds. Ideal body weight for height and age is 133-163#. Appetite is reported as varied. Recommend 1. Preferred snack list from resident/family and add these foods between meals. 2 Add 4-6 oz (ounces), OJ (orange juice), or Vitamin C fortified juice BID (twice daily). Continue to encourage intake.

On 5/1/12 at 8:11 A. M, dietary staff U reported, "The recommendations given to the DON

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(director of nursing), and he/she will then follow up. Staff stated," the recommendation for the extra protein (egg and extra meat), dated 1/10/14, had not been acted upon nor had the recommendations on 3/16/12, for additional snack between meals and orange juice. The snack cart goes out only in the evenings for the HS (bedtime) snack. I have crackers, fruit, cakes, donuts. We don't send out anything special for a pureed diet. The resident is on the special nutritional program, (super cereal), whole milk and the med pass. Anymore it is just automatic to start a resident on special nutrition program. I believe his/her meal consumption went down. If a see the resident in the dining room between meals, I offer a snack make a slurry out of graham crackers and vanilla wafers or something. Weight meetings are weekly, the MDS coordinator is over them."

On 5/1/12 at 1:55 P. M., administrative nursing staff B reported, " If the dietician has recommendations, it needs to go through the dietary manager first. If it is food then she can provide it, if it is medication then I will get it. I don't know why the resident did not receive the recommendations."

The clinical record lacked documentation facility staff initiated the dietary recommendations.

On 4/30/12 at 9:00 A. M., certified nursing staff M, " Reported the resident feeds himself, we have to encourage him/her to continue feeding self. The resident usually eats good, he/she likes to eat chocolate. The resident offered snacks, and walks all the time."

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On 4/30/12 at 9:00 A. M., licensed nursing staff 0 reported, "The resident needs encouragement and does feed self, and receives med pass. The family brings chocolate, he/she loves chocolate.

On 4/30/12 at 12:04 P. M., the resident's lunch tray of pureed spaghetti, creamed corn, jello cake. The resident also with 120 cc of nectar thickened milk, and 240 cc of thickened water, and a cup of coffee, thickened by the nurse. The resident ate all but the spaghetti, and ate all of the cream corn. The resident requested another bowl of cream corn. The resident ate the 2nd bowl of cream corn. Certified nursing staff , sitting at the table offering encouragement to the resident to complete the meal.

On 4/30/12 at 12:19 P. M., the resident given 90 cc of med pass to drink at the dining room table during lunch, by certified nursing staff G. Certified nursing staff G, returned 2 times to encourage the resident to complete the med pass.

On 4/30/12 at 12:30 P. M., the resident ate 2 servings of creamed corn and 1 serving of the jello cake and a few bites of the spaghetti, drank all of the med pass.

On 4/30/12 at 3:15 P. M., certified nursing staff N reported, " The resident eats in the assisted dining room. He/She needs reminders to eat at times. We give snacks in the evenings likes cookies and sandwiches."

On 5/1/12 at 8:00 A. M., the resident feeding self breakfast in the assisted dining room, ate 100% of the pureed diet, certified nursing staff P, encouraging the resident to eat. The resident

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drank all of his/her fluids including the med pass and milk.

On 5/1/12 at 2:00 P.M., administrative nursing staff C reported, "The resident's weight dropped because he/she was sick when first came here with the flu, then he/she fought 2 upper respiratory infections. The resident is doing better now. I don't know why the recommendations did not get started. We offer snacks, like a slurry with graham crackers or cookies, his/her family brings in chocolate."

The resident's meal intake for December 2011, documented the resident's meal intake of 25-65%.

The January 2012 meal intake, documented the resident ate 20-75% of meals. The resident ate 50-75% from 1/20/12 through 2/19/12. The resident ate 50-75% of meal from 2/19/12 through 3/1/12.

The March 2012 meal intake percentage for the resident is 60-100 % of diet.

The April 2012 meal intake percentage for the resident is 60-90% of diet.

On 5/3/12 at 11:00 A. M., administrative nursing staff B reported, " We do not have a policy relating to a resident who eats less than 75% of a meal. We do not routinely supplement if the resident eats less than 75% of their meal."

The facility policy for Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, revised October 2010, documented the

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F 325	Continued From page 57 following; " Assessment and Recognition ....3.) The threshold for significant unplanned and undesired weight loss will be based on the following criteria... a. 1 month -5% weight loss is significant; greater than 5% is severe. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. 6 months-10% weight loss is significant; greater than 10% is severe. Cause Identification ....1.) The physician will review possible causes of anorexia or weight loss with the nursing staff and/or Dietitian before ordering interventions. Treatment/Management....2.) The physician will authorize and the staff will implement appropriate general or cause specific interventions, as indicated, with careful consideration of the following;...b.) Nutritional needs: The dietitian will help the physician determine the appropriate diet for the resident based on the resident's degree of nutritional impairment, expressed wishes, and underlying causes and conditions. If the resident's nutritional or caloric needs have changed, but the diet has not, this may help to clarify the appropriate interventions." The facility failed to follow recommendations of the dietician on 1/10/12, to increase protein after the facility identified the resident with an 8.5% significant weight loss from 12/14/11 to 1/2/12, failed to follow recommendations of the dietician on 3/16/12 to supply a preferred snack between meals, and failed to have a system in place to	F 325		

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F 325	Continued From page 58 supplement the resident's meal intake when the resident consumed less than 75% of the meal served. The resident experienced a 23 pound/14.5% weight loss in less than 5 months, including significant weight loss of 21 pounds/13.29% in less than 3 months.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents,	F 329		

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with 10 residents selected for sample review of medication usage. Based on interview and record review, the facility failed to monitor 9 of the 10 residents reviewed for black box warnings, including resident #'s 5, 9, 49, 34, 32, 4, 6, 26, 35. Additionally, the facility failed to monitor 2 (#'s 12 and 26) of the 10 selected residents, for physician ordered laboratory testing, related to medication use.

Findings included:

- The facility admitted resident #5 on 1/9/07 with diagnoses including: multiple sclerosis, depressive disorder, anxiety disorder, vitamin deficiency, muscle spasm, osteoporosis, pain, stomach function disorder, and eye disorder.

The resident's 5/11/11 care plan, lacked identification of black box warnings, to instruct staff in the monitoring of the following warnings for tegretol and tylenol medication usage.

A quarterly, 1/30/12, MDS (minimum data set), identified the resident with a BIMS (brief interview of mental status) of 13, indicating cognitively intact.

A physician order, dated 2/28/12, documented Tegretol, 200 mg (milligrams), three times daily.

The 2011 Lexi-Comp Drug Information Handbook for Nursing, page 224-225, identified Tegretol with the following black box warning: "Potentially fatal blood cell abnormalities have been reported."

A physician order, dated 5/12/08, documented,

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F 329	Continued From page 60 Tylenol with Codeine #3, 300 mg/30 mg, 1 tablet, every 6 hours, prn (as needed) for pain. An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen." An interview, on 5/1/12 at 10:55 AM with administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and the list failed to identify the black box waring for the medication acetaminophen, therefore the staff member failed to care plan for the medication tylenol,s black box warning. The facility failed to adequately monitor this resident for the black box warnings associated with these medications (tegretol and tylenol). - The facility admitted resident #9 on 12/3/01. Diagnoses included: osteoarthrosis, reflux, depression, anxiety, incontinence, gastrointestinal hemorrhage, allergic rhinitis, chronic airway obstruction, bronchitis, skin disorders, seborrheic keratosis, pain, persistent insomnia, urinary frequency, hypertension, vitamin deficiency, panic disorder, constipation, paranoia, non-organic psychosis, depressive disorder, dementia with behavioral disturbance, Alzheimer's disease, hemorrhoids, and manic-depressive psychosis.	F 329		

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A physician's order, dated 10/14/08, documented, Tylenol, 325 mg (milligram), 2 tabs, prn (as needed), every 4 hours.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The resident's 3/7/11 care plan, failed to identify a black box warning for the use of Tylenol, to ensure staff monitoring for the warning.

An interview, on 5/1/12 at 10:55 AM with administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and the list failed to identify black box warning for the medication acetaminophen, therefore the staff member failed to care plan the black box warning for the medication Tylenol.

The facility failed to adequately monitor this resident for the black box warning associated with the medication, Tylenol.

- The facility admitted resident #49 on 11/2/11, with diagnoses including: bladder disorder, rheumatoid arthritis, abnormal weight loss, hypertension, heart failure, venous thrombosis, COPD (chronic obstructive pulmonary disease), esophageal reflux, vitamin deficiency, depressive disorder, acute pain, and a stage IV decubitus

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F 329	Continued From page 62 ulcer to the coccyx. The resident's 11/9/11 care plan, failed to instruct staff in the need to monitor black box warnings for the medication Norco, with a black box warning. A physician's order, dated 11/2/11, documented, Norco (a medication containing acetaminophen/Tylenol), 325 mg/5 mg, prn (as needed), four times daily. An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen." An interview, on 5/1/12 at 10:55 AM with administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and the list failed to identify the medication acetaminophen, therefore the staff member failed to care plan for the medication Tylenol. The facility failed to adequately monitor this resident for the black box warning associated with the medication, Tylenol, included in the resident's medication Norco. - The resident #34 admitted on 12/14/11, with the following diagnoses: malaise and fatigue, edema, rhinitis, allergic, keratosis, actinic; insomnia, unspecified malignant neoplasm other/face, hypothyroidism, vitamin deficiency,	F 329		

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hyperlipidemia, Alzheimer's, hypertension, and Benign neoplasm of skin (ear and external auditory canal).

The resident's care plan, dated12/26/12, failed to include a plan to monitor the adverse consequences of the Black Box Warnings for the medications, Toprol and Plavix.

The physician ordered Toprol-XL, 25 mg (milligrams), 1 by mouth daily for hypertension, dated 12/14/11.

The 2011 Lexi-Comp Drug Information Handbook for Nursing, page 933-936, identified the following black box warning, for Metoprolol (Toporol): "Warnings/Precautions [U.S. Boxed Warning]: Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with Coronary Artery Disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension, and/or ischemia."

The physician ordered Plavix, 75 mg, 1 by mouth daily for heart disease, dated 12/14/12.

The Lexi-Comp's Drug Information Handbook for Nursing, 2011-16th Edition, page 326; Warnings/Precautions [U. S. Boxed Warning]for Plavix: "Patients with one or more copies of the variant CYP2C19*2 and/or CYP2C19*3 alleles (and potentially other reduced-function variants) may have reduced conversion of clopidogrel to its active thiol metabolite. Lower active metabolite exposure may result in reduced platelet inhibition and, thus, a higher rate of cardiovascular events following myocardial infarction or stent thrombosis following percutaneous coronary

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F 329	Continued From page 64 intervention." On 4/30/12, at 4:15 P. M, administrative nursing staff C, reported, " I thought I did a black box warning for these medications. I use the list of medications from the pharmacy." On 4/30/12, at 4:15 P. M., administrative nursing staff B, reported, " We thought we had black box warnings on the care plan for toporal and plavix." The facility failed to develop a system and a plan of care to monitor for the adverse consequences associated with the administration of these medications with a black box warnings, to the resident. - A review of resident # 12's medical record revealed an admission date of 6/10/10, with diagnoses including: urinary frequency, nausea and vomiting, upper respiratory infection, anxiety, depressive disorder, pain in joint, hyperlipidemia, hypertension, atrial fibrillation, hemiplagia, cerebrovascular disease late effect dysphagia, osteroarthrosis, and esophageal reflux. A "Consultation Report," dated 2/22/12, revealed consultant staff J noted the resident on a PPI (protein pump inhibitor) and requested a physician's order to monitor magnesium levels. A physician's order, dated 3/21/12, directed staff to, "Magnesium [level] once day on the 1st of every 12th month" On 5/1/12 at 2:35 pm, administrative nursing staff B reported staff inputed the order into the facility's computer system, but did not print the order onto a list of the lab to draw. Staff B confirmed, the facility failed to obtain the lab as ordered.	F 329		

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F 329	Continued From page 65 The facility failed to adequately monitoring laboratory values related to the medications for this resident. - A review of resident # 35's medical record revealed an admission date of 3/19/12, with diagnoses including: nausea/ vomiting, dental disorder, chronic duodenal ileus, UTI (urinary tract infection), urinary frequency, debility, muscle weakness, Alzheimer's disease, tear film insufficiency, hypertension, cerebrovascular disease, peripheral vascular disease, asthma, constipation, esophageal disease, chronic pain, migraine, diploia, visual loss, anemia, presenile dementia, anxiety, tobacco use disorder, and depressive disorder. An undated care plan, revealed it lacked a black box warning for Tylenol (acetaminophen). A physician's order, dated 2/8/12, directed staff to administer, Tylenol with codeine #3, 300 mg / 3 mg, 1 tablet, orally, every 6 hours as needed. A physician's order, dated 3/27/12, directed staff to administer, Tylenol 325 mg, 2 tabs, orally, every 4 hours, as needed. A FDA (Federal Drug Administration), MedWatch for Tylenol (acetaminophen), dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."	F 329		

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F 329	Continued From page 66 On 5/1/12 at 8:45 am, administrative nursing staff B reported the consultant staff J and administrative nursing staff C review the black box warnings monthly and staff J provides a list of new black box warnings to staff C. On 5/1/12 at 10:55 am, administrative nursing staff C reported the pharmacy provides a list of the black box warnings for the facility's demographics. Staff C added, consulting staff J does not review the care plan. Staff C reported, "When I review the care plan, I try to make sure that all the relevant for the black box warnings for the medications are on the care plan." The facility failed to monitor for potential adverse effects of a medication which contains a black boxed warning for this resident who recieved Tylenol (acetaminophen). - A review of resident # 26's medical record revealed an admission date of 7/8/06, and a latest return date of 1/25/08, with diagnoses including: diabetes mellitus- type II, bacterial infection, cataracts, bladder disorder, skin disorders, coronary vessel atherosclerosis, cerebral artery with infarct, diabetes mellitus with neuro manifestation , diabetic proliferative retinopathy, dysphagia, pectoris angina, deficiency anemia, muscle disorder, glaucoma, tear film insufficiency, polyneuropathy in diabetes, constipation, generalized pain, history of urinary infection, cough, renal & ureteral disorder, anxiety disorder, vitamin deficiency, hyperlipidemia, magnesium metabolism disorder, depressive disorder hypertension, myocardial infarction,	F 329		

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transient cerebral ischemia, asthma, esophageal reflux, osteoporosis, disc degeneration, edema, urge incontinence, and allergy.
A physician's order, dated 1/25/08, directed staff to administer, Toprol XL, 50 mg (milligrams), 1 tablet, orally daily.
A physician's order, dated 1/25/08, directed staff to administer, Lortab (Hydrocodone/ acetaminophen) 5 mg / 500 mg, 1/2 tab, every 6 hours, as needed.
A physician's order, dated 12/1/10, Lortab (Hydrocodone/ acetaminophen) 5 mg / 500 mg, 1 tab, every 6 hours, as needed.
A physician's order, dated 10/14/08, directed staff to administer, Tylenol (acetaminophen), 325 mg, 2 tablets, orally, every 4 hours, as needed.
An undated "Medication care plan," revealed it lacked identification of Toprol XL and acetaminophen which contained black box warnings.

A FDA (Federal Drug Administration), MedWatch for Tylenol (aceaminophen), dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The 2011 Geriatric Dosage Handbook, 16th edition, page 1141, identified the following black box warning for Metoprolol (Toprol XL): [U.S. Boxed Warning]: "Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with Coronary Artery Disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension, and/or ischemia."

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F 329	Continued From page 68 On 5/1/12 at 8:45 am, administrative nursing staff B reported the consultant staff J and administrative nursing staff C review the black box warnings monthly and staff J provides a list of new black box warnings to staff C. On 5/1/12 at 10:55 am, administrative nursing staff C reported the pharmacy provides a list of the black box warnings for the facility's demographics. Staff C added, consulting staff J does not review the care plan. Staff C reported, "When I review the care plan, I try to make sure that all the relevant for the black box warnings for the medications are on the care plan." A physician's order, dated 10/14/08, directed staff to administer, Magnesium, 500 mg (milligrams), 1 tab, orally, daily. Lab results, dated 10/12/04, revealed a low Magnesium level of 1.4 mg/ dL (deciliter) with the therapeutic range of 1.6-2.6 mg/ dL. A physician's order, dated 6/29/10, directed staff to administer, Vitamin D, 400 international units, 1 tab, orally, once a day. Lab results, dated 11/18/09, revealed a low Vitamin D level of 24.2 ng (nanograms) / ml (milliliter) with the therapeutic range of 32.0 - 100.0 ng/ml. On 5/1/12 at 5:15 pm, administrative nursing staff B reported, "[The lab levels] should be completed every year, or so." Staff B confirmed the last labs checked for the Magnesium level obtained on 10/12/04, and for the Vitamin D level obtained on 11/18/09 . The facility failed to monitor for potential adverse effects of a medication which contains a black boxed warning for this resident. Furthermore the	F 329		

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facility failed to monitor the lab levels of medications for this resident.

- The medical record of resident # 4, was admitted on 07/29/2009, included diagnoses: constipation, hyperlipedimia, congestive heart failure, osteoarthritis, hypertension, esophogeal reflux, anemia, cardiovascular disorder, depression, angina pectoris, anemia, vitamin B deficiency, rheumatoid arthritis, hypercholesterolemia, anxiety, backache, chronic airway obstruction, edema, cornary disease, and chronic pain.

5-1-2012, Tylenol (acetaminophen) 500 mg (milograms), 2 tabs, by mouth, prn (as needed), every 6 hours, (not to exceet 4000mg in 24 hours).

The observation of the care plan on 4-30-12 revealed it failed to address black box warning for Tylenol (acetaminophen).

The Lexi-Comp Geriatric Dosage handbook, page 30 for acetaminophen as follows:
An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

5-1-2012, Mobic (Meloxicam), 7.5mg, daily.

The observation of the care plan on 4-30-12 revealed it failed to address black box warning for

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Mobic (Meloxicm).

The Lexi-Comp Geriatric Dosage handbook, page 888, indicates"...NSAIDS (non-steroidal anti-inflammatory drug) are associated with an increased risk of adverse cardiovascular thrombotic event, including MI and stroke." Furthermore,"...NSAIDS may increase the risk of gastrointestional irritation, inflammation, ulceration, bleeding and perforation."

5-1-2012, Bumex, 1 mg, daily.

The observation of the care plan on 4-30-12 revealed it failed to address black box warning for Bumex.

The Lexi-Comp Geriatric Dosage handbook, 16th Edition, Bumetanide (Bumex), page 207, indicating; Warning/Precautions (U.S Boxed Warning): Excessive amounts can lead to profound diuresis with fluid and electrolyte loss; close medical supervision and dose evaluation are required.

Interview with Administrative nursing staff C on 5-1-12 at 2:12 p.m., stated "The Omnicare pharmacy puts out a list for the black box warnings."

The facility, lacked a policy to instruct the staff on monitoring for adverse reactions related to medications with black box warnings.

The facility failed to develop a system to monitor the adverse consequences associated with the black box warning for the administration of Tylenol (acetaminophen, Mobic (Meloxicm) and

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F 329	Continued From page 71 Bumex. - The medical record of resident # 6, admitted on 12/02/2004, with the following diagnoses dementia without behavior disturbance, constipation, generalized pain, hypercholesterolemia, muscle/ligament disorder, allergies, osteoporosis, coronary artery anomaly, hypothyroidism, vitamin B12 deficiency anemia, depression, hypertension, cardiovascular disease, hemiplegia, atherosclerosis, female stress incontinence and esophageal reflux. A physician's order, dated 7-12-07, instructed Toprol SL (metoprolol) daily. The observation of the care plan on 4-30-12 revealed it failed to address black box warning for Toprol SL (metoprolol). The 2011 Lexi-Comp Drug Information Handbook for Nursing, Page 933-936, identified the following black box warning, for Metoprolol (Toprol): Warnings/Precautions (U.S. Boxed Warning): Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with coronary artery disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension and/or ischemia. A physician's order, dated 8-31-07, instructed Tylenol (acetaminophen) 325 mg 2 tablets every four hours prn (as needed). The Lexi-Comp Geriatric Dosage handbook, page 30 for (Tylenol) acetaminophen as follows:	F 329		

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An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."
Interview with Administrative nursing staff C on 5-1-12 at 2:12 p.m., stated "The Omnicare pharmacy puts out a list for the black box warnings."

The observation of care plan on 4-30-12 revealed it failed to address black box warnings to Metoprolol (Toprol) and Tylenol (acetaminophen).

The facility, lacked a policy to instruct the staff on monitoring for adverse reactions related to medications with black box warnings.

The facility failed to develop a plan of care and a system to monitor the adverse consequences associated with the black box warning for the administration of Toprol (metoprolol) and Tylenol (acetaminophen), for this resident
- The facility admitted resident # 32 on 11/15/2011, with most recent admission to the facility on 12/3/2011, with diagnoses including hypertension, anxiety, depressive disorder, and hemiplegia.

The Physician's orders revealed the following:

A Physician order on 11/23/2011 for - Tylenol regular strength 325 mg (milligram) 2 tablets every 4 hours as needed for pain in limb.

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An FDA (Federal Drug Administration), MedWatch for Tylenol/acetaminophen, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen".

A Physician order on 11/23/2011 for - Celebrex 200 mg 1 tablet once a day for osteoarthrosis.

The Lexi-Com Drug Information Handbook for Nursing, page 266, identified the following black box warning:

*Celebrex: "...NSAIDS are associated with an increased risk of adverse cardiovascular thrombotic events, including MI and strokes. "Furthermore, "...NSAID may increase the risk of gastrointestinal irritation, inflammation, ulceration, bleeding and perforation."

The care plan dated 3/18/2012, failed to address the adverse consequences associated with the black box warning for the medication's Tylenol, and Celebrex.
On 5/1/2012 at 10:55 am licensed nursing staff C reported that "The Pharmacy consultant provides a list of which medication that require black box warnings for our population. Our Pharmacist does not review each of the care plans to determine if the black box warning is on the care plans. When I review the MDS (minimum data set assessment), I review the list and try to make sure that all of the black box warnings for relevant medications are on the care plans."

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F 329	Continued From page 74 The facility lacked a policy and procedure for black box warnings to be placed on the residents care plans. The facility failed to develop a system and care plan to monitor for adverse consequences of administration of medications Tylenol, and Celebrex with black box warnings for this resident.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents, with 10 residents selected for sample review of drug regimen review. Based on interview and record review, the facility consulting pharmacist failed to identify and recommend to the facility the need to monitor 9 of the 10 residents reviewed for black box warnings, including resident #'s 5, 9, 49, 34, 32, 4, 6, 26, 35. Additionally, the consulting pharmacist failed to recommend laboratory testing for resident #26, and the facility failed to request laboratory monitoring, and the consultant pharmacist failed to follow up on the testing for resident #12, related to medication	F 428		

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use.

Findings included:

- The facility admitted resident #5 on 1/9/07 with diagnoses including: multiple sclerosis, depressive disorder, anxiety disorder, vitamin deficiency, muscle spasm, osteoporosis, pain, stomach function disorder, and eye disorder.

A physician order, dated 2/28/12, documented Tegretol, 200 mg (milligrams), three times daily.

The 2011 Lexi-Comp Drug Information Handbook for Nursing, page 224-225, identified Tegretol with the following black box warning: "Potentially fatal blood cell abnormalities have been reported."

A physician order, dated 5/12/08, documented, Tylenol with Codeine #3, 300 mg/30 mg, 1 tablet, every 6 hours, prn (as needed) for pain.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The resident's 5/11/11 care plan, lacked identification of black box warnings, to instruct staff in the monitoring of the following warnings for tegretol and tylenol medication usage.

An interview, on 5/1/12 at 10:55 AM with

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F 428	Continued From page 76 administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and the list failed to identify the black box waring for the medication acetaminophen, therefore the staff member failed to care plan for the medication tylenol,s black box warning. On 5/3/12 at 11:32 am, pharmacy consultant J, explained the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff confirmed, he/she does not review the resident ' s care plan. Staff discussed the [Pharmacy Name]-Reference Library, and acetaminophen not included on the list of medications with BBW, " I will have to check, that we aren ' t providing ...I will have to follow up. " The facility consultant pharmacist failed to recommend monitoring of this resident for the black box warnings associated with the medications, tegretol and tylenol. - The facility admitted resident #9 on 12/3/01. Diagnoses included: osteoarthrosis, reflux, depression, anxiety, incontinence, gastrointestinal hemorrhage, allergic rhinitis, chronic airway obstruction, bronchitis, skin disorders, seborrheic keratosis, pain, persistent insomnia, urinary frequency, hypertension, vitamin deficiency, panic disorder, constipation, paranoia, non-organic psychosis, depressive disorder, dementia with behavioral disturbance, Alzheimer's disease, hemorrhoids, and manic-depressive psychosis.	F 428		

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The resident's 3/7/11 care plan, failed to identify a black box warning for the use of Tylenol, to ensure staff monitoring for the warning.

A physician's order, dated 10/14/08, documented, Tylenol, 325 mg (milligram), 2 tabs, prn (as needed), every 4 hours.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

An interview, on 5/1/12 at 10:55 AM with administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and the list failed to identify black box warning for the medication acetaminophen, therefore the staff member failed to care plan the black box warning for the medication Tylenol.

On 5/3/12 at 11:32 am, pharmacy consultant J, explained the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff confirmed, he/she does not review the resident ' s care plan. Staff discussed the [Pharmacy Name]-Reference Library, and acetaminophen not included on the list of medications with BBW, " I will have to check, that we aren ' t providing ...I will have to follow up. "

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F 428	Continued From page 78 The facility consultant pharmacist failed to recommend black box warning monitoring to the facility, for this resident who received the medication, Tylenol. - The facility admitted resident #49 on 11/2/11, with diagnoses including: bladder disorder, rheumatoid arthritis, abnormal weight loss, hypertension, heart failure, venous thrombosis, COPD (chronic obstructive pulmonary disease), esophageal reflux, vitamin deficiency, depressive disorder, acute pain, and a stage IV decubitus ulcer to the coccyx. A physician's order, dated 11/2/11, documented, Norco (a medication containing acetaminophen/Tylenol), 325 mg/5 mg, prn (as needed), four times daily. An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen." The resident's 11/9/11 care plan, failed to instruct staff in the need to monitor black box warnings for the medication Norco which contained acetaminophen, with a black box warning. An interview, on 5/1/12 at 10:55 AM with administrative nursing staff C, reported the [consultant pharmacist] provided the facility a list of medications requiring black box warnings and	F 428		

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the list failed to identify the medication acetaminophen, therefore the staff member failed to care plan for the medication Tylenol.

On 5/3/12 at 11:32 am, pharmacy consultant J, explained the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff confirmed, he/she does not review the resident ' s care plan. Staff discussed the [Pharmacy Name]-Reference Library, and acetaminophen not included on the list of medications with BBW, " I will have to check, that we aren ' t providing ...I will have to follow up. "
The facility consultant pharmacist failed to recommend monitoring by the facility for this resident who received Norco, a medication with tylenol, which required a black box warning.
- The resident #34 admitted on 12/14/11, with the following diagnoses: malaise and fatigue, edema, rhinitis, allergic, keratosis, actinic; insomnia, unspecified malignant neoplasm other/face, hypothyroidism, vitamin deficiency, hyperlipidemia, Alzheimer's, hypertension, and Benign neoplasm of skin (ear and external auditory canal).

The physician ordered Toprol-XL, 25 mg (milligrams), 1 by mouth daily for hypertension, dated 12/14/11.

The 2011 Lexi-Comp Drug Information Handbook for Nursing, page 933-936, identified the following black box warning, for Metoprolol (Toporol): "Warnings/Precautions [U.S. Boxed Warning]: Beta-blocker therapy should not be withdrawn

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abruptly (particularly in patients with Coronary Artery Disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension, and/or ischemia."

The physician ordered Plavix, 75 mg, 1 by mouth daily for heart disease, dated 12/14/12.

The Lexi-Comp's Drug Information Handbook for Nursing, 2011-16th Edition, page 326; Warnings/Precautions [U. S. Boxed Warning]for Plavix: "Patients with one or more copies of the variant CYP2C19*2 and/or CYP2C19*3 alleles (and potentially other reduced-function variants) may have reduced conversion of clopidogrel to its active thiol metabolite. Lower active metabolite exposure may result in reduced platelet inhibition and, thus, a higher rate of cardiovascular events following myocardial infarction or stent thrombosis following percutaneous coronary intervention."
The resident's care plan, dated 12/26/12, failed to include a plan to monitor the adverse consequences of the Black Box Warnings for the medications, Toprol and Plavix.

On 4/30/12, at 4:15 P. M, administrative nursing staff C, reported, " I thought I did a black box warning for these medications. I use the list of medications from the pharmacy."

On 4/30/12, at 4:15 P. M., administrative nursing staff B, reported, " We thought we had black box warnings on the care plan for toporal and plavix."

On 5/3/12, at 11:32 A. M, consultant J, explained to the BBW (black boxed warnings), " We notify them [the facility] of the medications

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with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff confirmed, he/she does not review the resident ' s care plan. Staff discussed the(Pharmacy) Reference Library, and acetaminophen not included on the list of medications with BBW, " I will have to check, that we aren ' t providing ...I will have to follow up. "
The facility consultant pharmacist failed to identify the facilities failure to monitor for adverse reactions related to BBW for this resident who received Toprol XL and Plavix with BBW.

- A review of resident # 12's medical record revealed an admission date of 6/10/10, with diagnoses including: urinary frequency, nausea and vomiting, upper respiratory infection, anxiety, depressive disorder, pain in joint, hyperlipidemia, hypertension, atrial fibrillation, hemiplagia, cerebrovascular disease late effect dysphagia, osteroarthrosis, and esophageal reflux.
A "Consultation Report," dated 2/22/12, revealed consultant staff J noted the resident on a PPI (protein pump inhibitor) and requested a physician's order to monitor magnesium levels.

A physician's order, dated 3/21/12, directed staff to, "Magnesium [level] once day on the 1st of every 12th month."

The computerized medical record lacked follow-up documentation of the lab monitoring by the consultant pharmacist.

On 5/1/12 at 2:35 pm, administrative nursing staff B reported staff inputed the order into the facility's computer system, but did not print the order onto

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a list of the lab to draw. Staff B confirmed, the the facility failed to obtain the lab as ordered.

On 5/3/12 at 11:32 am, consultant staff J reported, "I would give them a couple of months [to obtain the lab results]... and follow up if the physician ordered it;" in regards to the follow-up on a request for lab monitoring.
The facility failed to act upon reccomendations by the consultant pharmacist to obtain lab test to monitor the resident's medications.

- A review of resident # 35's medical record revealed an admission date of 3/19/12, with diagnoses including: nausea/ vomiting, dental disorder, chronic duodenal ileus, UTI (urinary tract infection), urinary frequency, debility, muscle weakness, Alzheimer's disease, tear film insufficiency, hypertension, cerebrovascular disease, peripheral vascular disease, asthma, constipation, esophageal disease, chronic pain, migraine, diploia, visual loss, anemia, presenile dementia, anxiety, tobacco use disorder, and depressive disorder.

An undated care plan, revealed it lacked a black box warning for Tylenol (acetaminophen).

A physician's order, dated 2/8/12, directed staff to administer, Tylenol with codeine #3, 300 mg / 3 mg, 1 tablet, orally, every 6 hours as needed.

A physician's order, dated 3/27/12, directed staff to administer, Tylenol 325 mg, 2 tabs, orally, every 4 hours, as needed.

A FDA (Federal Drug Administration), MedWatch

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for Tylenol (acetaminophen), dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

On 5/1/12 at 8:45 am, administrative nursing staff B reported the consultant staff J and administrative nursing staff C review the black box warnings monthly and staff J provides a list of new black box warnings to staff C.

On 5/1/12 at 10:55 am, administrative nursing staff C reported the pharmacy provides a list of the black box warnings for the facility's demographics. Staff C added, consulting staff J does not review the care plan. Staff C reported, "When I review the care plan, I try to make sure that all the relevant for the black box warnings for the medications are on the care plan."

On 5/3/12 at 11:32 am, consultant staff J reported related to the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff J confirmed, he/she does not review the resident ' s care plan. Staff J discussed the [The Pharmacy]- Reference Library, and acetaminophen not included on the list medications with BBW, "I will have to check, that we aren ' t providing ...I will have to follow up."
The consultant pharmacist failed to identify the facility's failure to monitor for potential adverse effects of a medication which contains a black

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F 428	Continued From page 84 boxed warning for this resident who recieved Tylenol (acetaminophen) for this resident. - A review of resident # 26's medical record revealed an admission date of 7/8/06, and a latest return date of 1/25/08, with diagnoses including: diabetes mellitus- type II, bacterial infection, cataracts, bladder disorder, skin disorders, coronary vessel atherosclerosis, cerebral artery with infarct, diabetes mellitus with neuro manifestation , diabetic proliferative retinopathy, dysphagia, pectoris angina, deficiency anemia, muscle disorder, glaucoma, tear film insufficiency, polyneuropathy in diabetes, constipation, generalized pain, history of urinary infection, cough, renal & ureteral disorder, anxiety disorder, vitamin deficiency, hyperlipidemia, magnesium metabolism disorder, depressive disorder hypertension, myocardial infarction, transient cerebral ischemia, asthma, esophageal reflux, osteoporosis, disc degeneration, edema, urge incontinence, and allergy. A physician's order, dated 1/25/08, directed staff to administer, Toprol XL, 50 mg (milligrams), 1 tablet, orally daily. A physician's order, dated 1/25/08, directed staff to administer, Lortab (Hydrocodone/ acetaminophen) 5 mg / 500 mg, 1/2 tab, every 6 hours, as needed. A physician's order, dated 12/1/10, Lortab (Hydrocodone/ acetaminophen) 5 mg / 500 mg, 1 tab, every 6 hours, as needed. A physician's order, dated 10/14/08, directed staff to administer, Tylenol (acetaminophen), 325 mg, 2 tablets, orally, every 4 hours, as needed. An undated "Medication care plan," revealed it lacked identification of Toprol XL and	F 428		

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F 428	Continued From page 85 acetaminophen which contained black box warnings. A FDA (Federal Drug Administration), MedWatch for Tylenol (aceaminophen), dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen." The 2011 Geriatric Dosage Handbook, 16th edition, page 1141, identified the following black box warning for Metoprolol (Toprol XL): [U.S. Boxed Warning]: "Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with Coronary Artery Disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension, and/or ischemia." On 5/1/12 at 8:45 am, administrative nursing staff B reported the consultant staff J and administrative nursing staff C review the black box warnings monthly and staff J provides a list of new black box warnings to staff C. On 5/1/12 at 10:55 am, administrative nursing staff C reported the pharmacy provides a list of the black box warnings for the facility's demographics. Staff C added, consulting staff J does not review the care plan. Staff C reported, "When I review the care plan, I try to make sure that all the relevant for the black box warnings for the medications are on the care plan." A physician's order, dated 10/14/08, directed staff to administer, Magnesium, 500 mg (milligrams), 1 tab, orally, daily. Lab results, dated 10/12/04, revealed a low Magnesium level of 1.4 mg/ dL (deciliter) with the	F 428		

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F 428	Continued From page 86 therapeutic range of 1.6-2.6 mg/ dL. A physician's order, dated 6/29/10, directed staff to administer, Vitamin D, 400 international units, 1 tab, orally, once a day. Lab results, dated 11/18/09, revealed a low Vitamin D level of 24.2 ng (nanograms) / ml (milliliter) with the therapeutic range of 32.0 - 100.0 ng/ml. On 5/1/12 at 5:15 pm, administrative nursing staff B reported, "[The lab levels] should be completed every year, or so." Staff B confirmed the last labs checked for the Magnesium level obtained on 10/12/04, and for the Vitamin D level obtained on 11/18/09 . On 5/3/12 at 11:32 am, consultant staff J, reported related to the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff J confirmed, he/she does not review the resident ' s care plan. Staff J discussed the [The Pharmacy]- Reference Library, and acetaminophen not included on the list medications with BBW, "I will have to check, that we aren ' t providing ...I will have to follow up." Staff J added Vitamin D levels checked, " Usually annually." As a supplement, " If on 1000 unit or less, I would not necessarily ... just as a supplement." Staff J reported Magnesium levels monitoring reported, "I normally do not ... It's not a dose that would give you an over dose... If you requested it [a monitor level, it's probably reasonable. " The consultant pharmacist failed to identify the	F 428		

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facility's failure to monitor for potential adverse effects of a medication which contains a black boxed warning for this resident. Furthermore, the consulant pharmacist failed to monitor the lab levels of medications for this resident.

- The medical record of resident # 4, was admitted on 07/29/2009, included diagnoses: constipation, hyperlipedimia, congestive heart failure, osteoarthritis, hypertension, esophogeal reflux, anemia, cardiovascular disorder, depression, angina pectoris, anemia, vitamin B deficiency, rheumatoid arthritis, hypercholesterolemia, anxiety, backache, chronic airway obstruction, edema, cornary disease, and chronic pain.

A physician order, 5-1-2012, Tylenol (acetaminophen), 500 mg (milograms), 2 tabs, by mouth, prn (as needed), every 6 hours, (not to exceet 4000mg in 24 hours).

The care plan on 4-30-12, revealed it failed to address monitoring of a black box warning for Tylenol (acetaminophen).

The Lexi-Comp Geriatric Dosage handbook, page 30 for acetaminophen as follows:
An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

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A physician order, 5-1-2012, Mobic (Meloxicam), 7.5mg, daily.

The care plan on 4-30-12, revealed it failed to address black box warning for Mobic (Meloxicm).

The Lexi-Comp Geriatric Dosage handbook, page 888 for Mobic (Meloxicm), indicates"...NSAIDS (non-steroidal anti-inflammatory drug) are associated with an increased risk of adverse cardiovascular thrombotic event, including MI and stroke." Furthermore,"...NSAIDS may increase the risk of gastrointestional irritation, inflammation, ulceration, bleeding and perforation."

A physician order, 5-1-2012, Bumex, 1 mg, daily.

The care plan on 4-30-12, revealed it failed to address black box warning for Bumex.

The Lexi-Comp Geriatric Dosage handbook, 16th Edition, Bumetanide (Bumex), page 207, indicating; Warning/Precautions (U.S Boxed Warning): Excessive amounts can lead to profound diuresis with fluid and electrolyte loss; close medical supervision and dose evaluation are required.

Interview with Administrative nursing staff C on 5-1-12 at 2:12 p.m., stated "The pharmacy puts out a list for the black box warnings."

On 5/3/12 at 11:32 a.m., the Consultant Facility Pharmacist staff J, reported related to the BBW (black boxed warnings), "We notify them (the facility) of the medications with the BBW. I don't write the specific drug....a list (of the medications

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F 428	Continued From page 89 containing the BBW) provided through the pharmacy. Staff confirmed, he/she does not review the resident's care plan. Staff discussed the Pharmacy Reference Library, and acetaminophen not included on the list medications with BBW, "I will have to check, that we aren't providing...I will have to follow-up." The facility, lacked a policy to instruct the staff on monitoring for adverse reactions related to medications with black box warnings. The Consultant facility pharmacist, failed to identify the facility failure to monitor the adverse consequences associated with black box warnings for the administration of Tylenol (acetaminophen), Mobic (meloxicm) and Bumex for this resident. - The medical record of resident # 6, admitted on 12/02/2004, with the following diagnoses dementia without behavior disturbance, constipation, generalized pain, hypercholesterolemia, muscle/ligament disorder, allergies, osteoporosis, coronary artery anomaly, hypothyroidism, vitamin B12 deficiency anemia, depression, hypertension, cardiovascular disease, hemiplegia, atherosclerosis, female stress incontinence and esophageal reflux. A physician's order, dated 7-12-07, instructed Toprol SL (metoprolol) daily. The care plan on 4-30-12, revealed it failed to address the black box warning for Toprol SL (metoprolol).	F 428		

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The 2011 Lexi-Comp Drug Information Handbook for Nursing, Page 933-936, identified the following black box warning, for Metoprolol (Toprol): "Warnings/Precautions (U.S. Boxed Warning): Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with coronary artery disease), but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension and/or ischemia."

A physician's order, dated 8-31-07, instructed Tylenol (acetaminophen), 325 mg, 2 tablets, every four hours prn (as needed).

The Lexi-Comp Geriatric Dosage handbook, page 30 for (Tylenol) acetaminophen as follows: An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."
Interview with Administrative nursing staff C on 5-1-12 at 2:12 p.m., stated "The pharmacy puts out a list for the black box warnings."

The care plan on 4-30-12, failed to address black box warnings for Metoprolol (Toprol) and Tylenol (acetaminophen).

On 5/3/12 at 11:32 a.m., the Consultant Facility Pharmacist staff J, reported related to the BBW (black boxed warnings), "We notify them (the facility) of the medications with the BBW. I don't write the specific drug....a list (of the medications

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containing the BBW) provided through the pharmacy. Staff confirmed, he/she does not review the resident's care plan. Staff discussed the Pharmacy Reference Library, and acetaminophen not included on the list medications with BBW, "I will have to check, that we aren't providing...I will have to follow-up."

The facility, lacked a policy to instruct the staff on monitoring for adverse reactions related to medications with black box warnings.

The Consultant facility pharmacist, failed to identify the facility failure to monitor the adverse consequences associated with black box warnings for the administration of Tylenol (acetaminophen) and Metoprolol (Toprol) to the resident.
- The facility admitted resident # 32 on 11/15/2011, with most recent admission to the facility on 12/3/2011, with diagnoses including hypertension, anxiety, depressive disorder, and hemiplegia.

The Physician's orders revealed the following:

A Physician order on 11/23/2011 for - Tylenol regular strength, 325 mg (milligram), 2 tablets, every 4 hours, as needed for pain in limb.

An FDA (Federal Drug Administration), MedWatch for Tylenol/acetaminophen, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen".

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F 428	Continued From page 92 A Physician order on 11/23/2011 for - Celebrex, 200 mg, 1 tablet, once a day for osteoarthrosis. The Lexi-Com Drug Information Handbook for Nursing, page 266, identified the following black box warning: *Celebrex: "...NSAIDS are associated with an increased risk of adverse cardiovascular thrombotic events, including MI and strokes. "Furthermore, "...NSAID may increase the risk of gastrointestinal irritation, inflammation, ulceration, bleeding and perforation." A review of the care plan dated 3/18/2012, failed to address the adverse consequences associated with the black box warning for the medication's Tylenol, and Celebrex. On 5/1/2012 at 10:55 am, licensed nursing staff C reported " The Pharmacy consultant provides a list of which medication that require black box warnings for our population. Our Pharmacist does not review each of the care plans to determine if the black box warning is on the care plans. When I review the MDS (minimum data set assessment), I review the list and try to make sure that all of the black box warnings for relevant medications are on the care plans." On 5/3/12 at 11:32 am, consultant J, reported related to the BBW (black boxed warnings), " We notify them [the facility] of the medications with the BBW. I don ' t write the specific drug ... a list [of the medications containing the BBW] provided through the pharmacy. " Staff confirmed, he/she does not review the resident's care plan. Staff discussed the Pharmacy Reference Library, and	F 428		

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F 428	Continued From page 93 acetaminophen not included on the list medications with BBW, " I will have to check, that we aren' t providing ...I will have to follow up. " The facility lacked a policy and procedure for black box warnings to be placed on the resident's care plans. The facility pharmacist failed to identify the facility failure to monitor the adverse consequences associated with the black box warnings for the administration of acetaminophen, and Celebrex for this resident.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 94 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on observation, interview, and record review, the facility failed to maintain an infection control program to prevent, to the extent possible, the potential spread of infections, as witnessed on 2 of the 4 days of the survey, in one unsampled resident room. Findings included: - On 4/25/12 at 1:44 pm, within one resident's room on the west hall, a nebulizer machine and tubing sat directly on the floor, beside the oxygen concentrator. On 4/30/12 at 10:00 am, the nebulizer machine and tubing again sat directly on the floor, beside the oxygen concentrator. On 5/2/12 at 2:30 pm, administrative nursing staff B confirmed the nebulizer which sat directly on the floor as inappropriate storage.	F 441		

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ARMA CARE CENTER LLC	605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 95 The facility policy and procedure for, "Administering Medications through a Small Volume (Handheld) Nebulizer," revised October, 2010, documented, "...When equipment is completely dry, store in a plastic bag with the resident's name and the date on it..." The facility failed to maintain an infection control program to prevent, to the extent possible, the potential spread of infections, to the residents of the facility.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on observation and interview, the facility failed to provide a fully functioning call light system to 16 of 25 resident rooms on the west hall and 10 of 21 resident rooms on the east hall including the central resident bathroom. Findings include; - During environmental tour, on 5/1/12, at 10:30 A. M., the call light system failed to function properly on the west and eas residentt hallways. Examples include the following; West hallway;	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175353	A. BUILDING _____ B. WING _____	05/03/2012

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F 463	Continued From page 96 1.) In six resident room's, the call light turned on the light above the room door and sounded, but failed to light up on the panel at the nurses station. 2.) In nine resident room's, the call light turned on the light above the room door and sounded, but failedto light up as a different room number. 3.) In two resident room's, bathrooms, the call light did sound. One failed to light up a the bathroom, and in the other bathroom, the light outside the door failed to light up, 4.) In one resident room's the call light control switch turned itsself off and on when used. 5.) In one resident's room the call light reset panel failed to function. 6.) In the soiled utility room, the call light indicator failed to sound and/or light. East hallway; 1.) In two resident rooms, the call light turned on the light above the door, but failed to light number on the panel at the nurses station. 2.) In two resident rooms, the call light turned on the light above the door, but failed to light up at the panel located at the nurses station. 3.) In eight resident rooms, the call light functioning above the door, but on the panel it	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 463	Continued From page 97 lights up as a different room. On 5/2/12 at 10:30 A. M., maintenance staff H, reported, " I check the call lights every week. I did not write this down. I am aware the call lights are not lighting in the panel at the desk." The facility failed to maintain a full functioning call light system, to ensure the residents recieved assistance when needed..	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on observation and interview, the facility failed to provide maintenance and housekeeping services, in 1 of 1 laundry areas, necessary to maintain a functional and sanitary environment. Findings included: - The environmental tour on 5/1/12 at 10:30 am, with maintenance staff H and laundry/ housekeeping staff I revealed the following: The laundry area, located in another building, behind the facility, contained siding of discolored and crumbling material, on all 4 sides of the building, upward approximately 6 inches.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 98 The clothing " folding " table lacked a 6 inch section of laminate on the outer edge, with paint missing from the wooden section, thus making it a non cleanable surface. The cabinets beside and below the "folding" table contained a black grime and black scuff marks on the doors and cabinet frames. The wall beside the cabinets contained a 1 foot by 1 foot area of worn paint. On 5/1/12 at 10:30 am, maintenance staff H confirmed, "Yes, it [the laundry building] needs new siding and the folding table is missing the laminate. " The facility failed to provide maintenance and housekeeping services necessary to maintain a functional and sanitary environment for the laundry area.	F 465		